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***Nurses as Role Models in Health Promoting Behaviour:
Concept Development and Analysis***

Joy Louise Darch

A thesis submitted for the degree of Professional Doctorate in Health

University of Bath

Department of Health

2016

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Abstract

There are national and international expectations for nurses to be role models in health promoting behaviour despite little existing research exploring or defining the concept within nursing theory. This study aimed to i) promote theoretical clarity for the concept of the nurses being role models in health promoting behaviour and ii) investigate student nurses, nurse educators and registered nurses' experiences and perceptions of the concept.

A hybrid, concept analysis and development framework was developed for this study which involved a theoretical, fieldwork and final analytical phase. The theoretical phase of the study firstly involved analysis of multi-disciplinary literature to determine uses of the term 'role model' and secondly, analysis of nursing literature to identify antecedents, attributes and consequences to the concept of nurses as role models in health promoting behaviour. The fieldwork phase involved a qualitative study of six focus groups and one interview, which included participants from a range of NHS Trusts and independent organisations across London and South East England. Student nurses, nurse educators and registered nurses' (RNs) were recruited to capture opinions and experiences about being healthy role models from across the profession and to explore their understanding of what the concept actually means. Thematic analysis of qualitative data contributed to further identification of antecedents, attributes and consequences and identification of model, contrary, borderline and related cases. The final analytical phase involved integrating findings from fieldwork and theoretical phases and considering: i) the relevance of the concept, ii) if the selection of the concept seems justified, and iii) to what extent the theoretical and empirical analysis support the presence and frequency of the concept within the population under study

The adapted hybrid framework developed for this study went beyond analysis of literature to provide the following definition: *Being a role model in health promoting behaviour involves being an exemplar, portraying a healthy image (being fit and healthy), and championing health and wellness. Personal attributes of a role model in health promoting behaviour include being: caring,*

non-judgemental, trustworthy, inspiring and motivating, self-caring, knowledgeable and self-confident, innovative, professional and having a deep sense of self. Thematic analysis of qualitative data provided insight into factors perceived to affect the ability or desire to act as healthy role models. Thus qualitative data highlighted perceived personal, educational, societal and organisational complexities surrounding the requirement to be role models. Many participants in this study were unaware of the NMC requirement to be role models in health promoting behaviour and did not understand what is meant by the concept. Although most participants perceived being a healthy role model as important to their role as a nurse many considered that working as a nurse did not support their own health and considered working environments unhealthy. Some participants disagreed with the requirement to be a healthy role model and many felt undervalued by their organisations, which they considered a barrier to being a healthy role model.

If nurses continue to be expected to act as healthy role models, understanding of the complexities identified in this study can help inform nurses, nurse educators, health care organisations and policy makers to support the profession to meet that expectation.

Abbreviations

BMI	Body Mass Index
CHD	Coronary Heart Disease
DH	Department of Health
HCP	Health Care Professional
HPCSES	Health Promotion Counselling Self Efficiency Scale
ICN	International Council of Nurses
NHS	National Health Service
MRM	Modeling and Role Modeling Theory
NMC	Nursing and Midwifery Council
NOC	Nursing Outcomes Classification
RCN	Royal College of Nursing
RN	Registered Nurse
RSPH	Royal Society for Public Health
SARMHEP	Self as Role Model for Health Promotion
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WHO	World Health Organisation

Chapter 1: Introduction

1.1. Introduction

There is increasing expectation in the United Kingdom (UK) for nurses and healthcare professionals to be role models in health promoting behaviour. However, the expectation is not consistent with the reality of nurses' health. Many National Health Service (NHS) staff are obese or overweight, lack sufficient physical exercise, smoke or have poor nutrition (Blake et al., 2011, Blake et al., 2012, Blake and Patterson, 2015). International research suggests that this situation is not limited to the UK (Timmins 2011, Miller et al 2008, Zapka et al., 2009, King et al 2009, Clarke et al 2004). There is rising media coverage surrounding the health of nurses; NHS England chief executive, Simon Stevens claimed that overweight doctors and nurses should set a good example to patients and slim down, claiming that approximately 700,000 of 1.3 million NHS staff are either overweight or obese (Guardian, 2014). The expectation for healthy role models is evident in government documents (DH 2009, 2010, 2011):

“nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health” (DH 2010: 6).

A statutory requirement for nurse registration with The Nursing and Midwifery Council (NMC); the UK regulatory body for nursing and midwifery, is:

“all nurses must take every opportunity to encourage health promoting behaviour through education, role modelling and effective communication” (NMC., 2015).

The NMC does not explain what role modelling in the context of health promoting behaviour means. Interest in the topic has also been captured on social media; 89 participants contributed to 567 Tweets on Twitter Chat (WeNurses, 2016), debating whether being a role model for healthy behaviour was considered a professional duty by nurses.

Role modelling health-promoting behaviour is on the international agenda to address rising chronic disease. The International Council of Nurses (ICN., 2010) state that:

“If each of the world’s 13 million nurses made a personal commitment to eat healthily, exercise appropriately, and avoid the use of tobacco, this would improve their health and well-being and reduce the likelihood of their developing chronic disease. If each of these nurses acted as role models, educators and change agents among their families, friends, workplaces and local communities to promote healthier lifestyles, together we could help to halt the tide of chronic disease.” (ICN 2010: 37)

For the purpose of this thesis the terms healthy role models and role models for healthy lifestyles are considered consistent with role models for health promoting behaviour.

1.2 Origins of Interest

The origin of interest for this thesis began while I was teaching at a large university in the West of England. Smoking levels and alcohol consumption appeared high and colleagues were reporting increased tutorial support for students suffering with stress. Student nurses told me they considered unhealthy lifestyle behaviours to be caused by the pressures of nursing. At a pre-Christmas celebration, students brought to class, large volumes of high fat, high sugar snacks and fizzy drinks to consume. The celebration appeared to provide an opportunity for extended smoking breaks, which appeared incongruent on a work based learning day designed to relate theory to practice. Consequentially a discussion developed whether student nurses should set a good example to patients by demonstrating healthy lifestyle behaviours. The debate was overwhelming; many considered their role should not influence personal lifestyle, while some felt they should set an example by practising what they preach. Reflecting on the debate generated my interest in lifestyle behaviours of nurses and nurses as healthy role models. Subsequently, throughout my role in nurse education I informally explored the topic whilst

teaching registered nurses. It appears that there are mixed opinions amongst nurses whether the requirement to be role models in health promoting behaviour is considered reasonable and one aim of this study was to explore that issue.

1.3 Definitions of key terms

There were no available dictionary definitions for role modelling health promoting behaviour or healthy role models. Therefore, definitions were sought for the key terms of 'role model' (Table 1.1) 'health promoting behaviour', 'health promotion' and 'health behaviour'.

Table 1.1: Dictionary definitions of 'role model'

Dictionary	Definition
Oxford University Press 2014.	A person looked to by others as an example to be imitated
Collins English Dictionary - Complete & Unabridged 2012 Digital Edition	A person regarded by others, especially younger people, as a good example to follow
The American Heritage® Stedman's Medical Dictionary	A person who serves as a model in a particular behavioural or social role for another person to emulate

Searches in dictionaries for the term health promoting behaviour did not provide results with the exception of one medical dictionary:

“a nursing outcome from the Nursing Outcomes Classification (NOC) defined as personal actions to sustain or increase wellness” (Mosby, 2009).

The World Health Organisation (WHO) defines health promotion as:

“the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual

behaviour towards a wide range of social and environmental interventions” (WHO, 2015).

A health behaviour is defined as an activity undertaken by someone who believes they are healthy, to prevent disease or detect disease before symptoms occur (Kasl and Cobb, 1966), or “an action taken by a person to maintain, attain, or regain good health and to prevent illness. Health behavior reflects a person's health beliefs. Some common health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary inoculations” (Mosby 2009). Many publications make reference to health behaviours or poor health behaviours of nurses and these are discussed in Section 1.4.

The definitions in this Section provided a fragmented, simplistic approach to the overall concept of role modelling health-promoting behaviour from which I constructed a preliminary definition for this study: ‘to provide an example of personal actions to sustain or increase wellness serving as a model for others to emulate’.

1.4 Health behaviours of nurses

There is evidence that health behaviours of many nurses do not meet NMC and ICN expectations to be healthy role models. Publications from outside of the UK demonstrate high levels of smoking, obesity, stress and alcohol consumption (Miller et al., 2008, Clark et al., 2004, King et al., 2009). Miller et al. (2008) surveyed 760 nurses in the United States of America (USA); 22% were obese and 32% overweight. Of those ($n=307$) who specifically counselled healthy diet practices 18% were obese and 35% overweight. Over half of the respondents did not feel competent to provide weight related advice to patients. The response rate for the study was low (15.5%), which could suggest the figures for weight were higher than indicated; those that did not volunteer might have avoided recruitment due to the nature of the topic.

Australian student nurses ($n=366$) completed a smoking and health promotion questionnaire developed in Ireland (Clark et al., 2004). Participants had higher smoking levels than the general public and knowledge about the effects of

smoking was inconsistent with attitudes about the habit. Clark et al. (2004) conducted the study on one university site, however response rate was high and the sample was representative of students. King et al. (2009) conducted a 65-item survey of US nurses ($n=435$) to examine eating disorders related to job stress. Nurses with high levels of perceived work stress reported eating when stressed. The strength of the study was the validation process of the survey and a sample size, which exceeded the power calculation.

Perry et al. (2015) argue there are early warning signs concerning the health of nurses in Australia, following their cross sectional study ($n=381$) using a validated survey across two hospital sites. Ninety percent of RNs ($n=358$) reported they had good health, however, 43% ($n=164$) had chronic disease, which questions nurses' perceptions of good health. Risk factors to health were identified as alcohol intake, overweight and obesity and lack of health screening (Perry, 2009). However demographic differences across sites suggest that findings may not be from a representative sample.

There is evidence of unhealthy lifestyles in UK nurses. Student nurses ($n=186$) in Scotland completed the European Health and Behaviour Survey (Watson et al., 2006). Twenty-eight percent of participants were smokers (3% higher than the general population); 86% of smokers claimed to want to cease smoking. Seventy-four percent exceeded the benchmark for daily alcohol intake at least once during the week of the study and 55% reported binge drinking. While this was a relatively small, one site study, strengths were the high response rate (93%), and the well-recognised validated tool.

Malik et al (2011) conducted secondary analysis of self-reported health and lifestyle behaviour data collected from pre-registration nursing students and RNs ($n=876$) from a NHS trust. The aim of the study was to identify how participants were transferring knowledge of healthy lifestyles to personal behaviour. Almost half were found to fail public health recommendations for physical activity, two thirds consumed less than five fruit or vegetable portions a day and almost half ate high sugar and fat foods every day. With the exception of smoking, RNs had a healthier lifestyle compared to student nurses. Data for this study was collected from two existing data sets, therefore causal

relationships could not be considered. As with any study relying on self-reported data, the chance of participants providing socially desirable responses affects validity. However, surveys remained anonymous.

Timmins et al. (2015) surveyed 246 Dublin student nurses to assess eating habits, smoking, alcohol consumption, other substance use, accidents and injuries, sexual health, exercise, mental health and general health. The study was conducted across two sites using a 146 item self-reporting questionnaire based on the College Lifestyle and Attitudinal National Survey (CLAN). An aim of the study was to identify stressors associated with nurse education and to examine the impact on student lifestyle behaviours. 36.6% reported to be smokers. Almost half of the participants reported alcohol consumption as mostly sociable, however 26.4% claimed to drink alcohol to relax, 15% to forget worries, and 4.5% because they were anxious or depressed. Unprotected sex due to alcohol consumption was reported by 11.4% of participants. Only three quarters considered their mental health good and principal stressors were identified as assessments, studies and finances (Timmins et al., 2011). A strength of the study was the pilot study, which tested the questionnaire, however reliability of findings could have been affected by socially desirable responses.

Health behaviours and attitudes to being a role model of 540 UK pre-registered nurses were assessed using a self-reporting questionnaire (Blake and Harrison, 2013). Key findings were: participants believed they should be role models for healthy behaviour, weight and image were considered important to how people perceived nurses and personal lifestyle of nurses were considered influential to lifestyle choices of patients. Despite these attitudes 46.9% did not meet public health recommendations for physical activity, 24% were overweight or obese, 73% did not consume five portions of fruit and vegetables a day, 40% claimed to binge drink and 17% smoked. Self-reporting in this study suggests that findings might be underestimated. Blake and Harrison (2013) considered student nurse health behaviours less than exemplary and that attitudes to being role models were inconsistent with personal health behaviours. Participants

claimed (60%) that nurse education had not influenced their health behaviours, however of those that felt it had; most were overweight.

Sixty seven paediatric nurses from fourteen wards in an UK acute setting completed questionnaires to assess attitudes to promoting healthy eating and being role models for health (Blake and Patterson, 2015). Most (84%) felt they should present themselves as healthy role models. However, 48% considered it difficult to promote healthy behaviours to patients because they did not adhere to such lifestyles themselves. Evidence surrounding lifestyle choices demonstrated that most did not consume five fruit or vegetable portions a day, 45% were overweight or obese and 30% did not meet public health physical activity recommendations. Blake and Patterson (2015) identified barriers and facilitators for being healthy role models, which will be discussed in Chapter 2.

The health of nurses was the focus for two systematic reviews. The first (Fronteira and Ferrinho, 2011), prompted by lack of evidence on the subject focused on physical health. Studies ($n=187$) included in the review dealt with issues such as musculoskeletal problems, cancer, hypertension, cardiovascular disease, allergies and asthma. Evidence suggested a link between health problems and the nursing occupation. However, most studies were argued to be weak and lacking in external validity. Little reference was made to causal effects of health behaviours of nurses. A systematic literature review protocol (Neall et al., 2015) for prevalence of smoking, physical activity, diet and alcohol consumption has been published, which claims there is a lack of evidence of nurses health related behaviours. Findings of the review, at the time of writing were not available.

In contrast there is evidence that cardiac nurses appear to have adopted healthier lifestyles ((UNITE), 2002, Connolly et al., 1997, Jaarsma et al., 2004). Cardiac nurses ($n=130$) attending a European conference participated in health-screening interviews; most had a healthier lifestyle than the general population. ((UNITE), 2002). This was later confirmed by a study (Jaarsma et al., 2004) of cardiac nurses in the Netherlands ($n=122$) which measured coronary heart disease (CHD) risk rate. Jaarsma et al., (2004) demonstrated that most participants heeded advice they gave patients and were considered

be good role models for primary and secondary prevention initiatives. However, the low response rate might indicate that those with a higher CHD risk rate did not volunteer.

Overall literature confirmed that health behaviours of many nurses do not meet NMC and ICN expectations to be healthy role models.

1.5 Clarity of concept

Role modelling healthy behaviour is of national and international interest and the term is widely used within nursing literature (Blake et al., 2011, Miller et al., 2008, Rush et al., 2005b, Timmins 2011, Zapka et al., 2009) with the assumption of agreed understanding and plausibility of the concept. There is however very little existing research exploring the concept within nursing theory despite NMC and ICN expectations. Furthermore, the use of the term role model in the context of encouraging health promoting behaviour is far removed from the original meaning. The term role model evolved from work by Robert Merton in the 50s (Holton 2004), which advanced understanding of social groups. Merton researched socialisation of medical students in Columbia and the term role model was developed from his theory of the 'reference group'; the group, which people compare themselves with, which is not always the group to which they belong (Merton, 1968). Merton suggested that individuals compare themselves to groups in which they aspire to belong. Merton focused on medical students and considered the identification of a role model not so prevalent in other professions. He provided evidence that lawyers were not able to identify a role model within their profession as easily as doctors (Merton, 1968). Nursing literature retrieved for this thesis did not refer to Merton's work, which would suggest that the meaning of the concept has evolved since its origins to the working use of the term used by the NMC today.

Role modelling in nursing literature mostly refers to role modelling professional behaviour; demonstrated by a recent integrative literature review (Baldwin et al., 2014). Chapter 2 of this thesis presents a review of literature, which describes the theory of modeling and role modeling (MRM). This theory, which originated in the US and began in the 1980s, is not well cited in UK publications.

Role Modelling in this context is described as a theory or paradigm of nursing that provides a holistic foundation for practice, education and research (Schultz, 2009).

The work of Kathy Rush et al., (2005b) in Canada contributed to some knowledge of nurses understanding of health promoting role models. The small study ($n=15$) identified that the term evoked diverse interpretations by conducting focus groups and interviews. The authors (Rush et al., 2005b) provided a conceptual schema, which, included definitions of an idealised role model but also captured a humanistic understanding of being an imperfect role model. Personal and professional definitions of role modelling therefore included valuing health, accepting self with imperfections, engaging in self reflections, gaining trust, caring and partnering. This preceded the development of a measurement tool for nurses' perceptions of themselves as role models; further discussed in Chapter 2 (Rush et al., 2010).

There remains a gap in knowledge of how UK nurses define the concept of being role models in health promoting behaviour. If UK student nurses are required to meet the NMC statutory requirement for registration to become role models in health promoting behaviour it is important to clarify what is understood by the concept.

1.6 Aims and structure of the thesis

The research questions for this study are:

- What does the term role modelling in health promoting behaviour currently mean to the nursing profession?
- What are nurses' attitudes towards role modelling health promoting behaviour in the context of the requirement for student nurses to become role models in health promoting behaviour?

The broad aims of this study are to:

- promote theoretical clarity for the concept of role modelling in the context of the professional body requirement for student nurses to become role models in health promoting behaviour
- investigate student nurses, nurse educators and registered nurses' experiences and perceptions of role modelling health-promoting behaviour

The aims of this study will be addressed by: 1) analysing the concept of nurses as role models in health promoting behaviour within the literature, 2) exploring opinions, values and beliefs surrounding the phenomenon of role models in health promoting behaviour with student nurses, RNs and nurse educators, 3) exploring experiences in practice: what is observed of RNs encouraging health-promoting behaviour through role modelling, 4) exploring whether student nurses, RNs and nurse educators perceive that the educational experience prepares students to meet the requirement to role-model health promoting behaviour as RNs and whether any improvements could be made, 5) exploring factors which student nurses, RNs and nurse educators perceive to affect their ability or desire to act as role models in health promoting behaviour.

To meet the broad aims of the present study to investigate student nurses, nurse educators and registered nurses' experiences and perceptions of role modelling health-promoting behaviour, literature and qualitative data from all groups will be analysed together, and this process, together with the rationale which are further discussed in Section 3.4.2.

This thesis is structured in the following way:

Chapter Two provides a critical review of the literature surrounding nurses as role models in health promoting behaviour.

Chapter Three outlines, explains and justifies the three-phase methodological concept analysis and development framework used for this study. These phases are theoretical, fieldwork and final analytical. The epistemological stance is explained and consideration given to trustworthiness of this study. Data collection and analysis methods are described. Finally, consideration is given to ethical issues.

Chapter Four presents research findings from the theoretical phase of this study. This includes analysis of two literature searches; 1) identifies cross discipline uses of the term role model 2) concept analysis of literature surrounding the concept of nurses as role models in health promoting behaviour.

Chapter Five presents thematic analysis of the fieldwork, qualitative, phase of the study. Qualitative data is analysed from six focus groups involving student nurses, RNs and nurse educators. One individual interview is also included.

Chapter Six outlines the final analytical phase of the study. This phase combines theoretical analysis of existing literature and previous research with qualitative data gathered from focus groups.

Chapter Seven interprets and analyses findings of the study surrounding the meaning of the concept of nurses as role models. Consideration is given to implications for nursing, nurse education, organisation, policy and the wider public health agenda. Discussions and conclusions include the strengths and limitations of this study and consideration of further research.

Chapter 2: Literature Review

2.1 Introduction

This chapter critically reviews literature relevant to nurses as role models in health promoting behaviour. Relevant theoretical frameworks identified from the literature are discussed. The role of the nurse in health promotion and public health is considered. Existing evidence surrounding efficacy of nurses as healthy role models is examined. Nurses have negative and positive views towards being healthy role models and these are discussed. Finally, barriers and facilitators to being role models in health promoting behaviour are identified from nursing literature. Literature discussed throughout this chapter considers published studies with both registered nurses and student participants interchangeably and one study includes data from both groups (Moxham et al., 2013). For the purpose of appraising literature in this chapter the groups were not separated, however the narrative identifies whether the published data was collected from students, registered nurses or both.

2.2 Theoretical frameworks

Relevant theoretical frameworks were identified within the literature surrounding nurses as role models in health promoting behaviour.

2.2.1 Social Cognitive or Learning Theory

Bandura's social cognitive or learning theory was cited as relevant in many publications. Albert Bandura's work on social behaviours and learning commenced in the 60s. His experiments studied observational learning of children's behaviour, which suggested that people learn through observing, imitating, and modelling (Bandura, 1977). This work preceded social cognitive theory (Bandura, 1986), which holds that learning occurs in a social context. Social cognitive theory is based on the premise that learned behaviours are central to individual personality, and are learned through factors, which include observing others, the environment and behaviour. Reproducing an observed behaviour is influenced by three determinants; 1) response received after a behaviour, 2) low or high self-efficacy towards a behaviour; whether they

believe they have the ability to behave in a certain way, and 3) aspects of their environment affect the ability to behave a certain way.

Depth of reference made to Bandura's work within the literature varied considerably. Some authors made brief reference to Bandura; others applied the theoretical framework to underpin the entire perspective of the study.

First year physiotherapy and nursing students ($n=204$) completed questionnaires to assess adherence to healthy lifestyles across three Swedish universities (Kamwendo et al., 2000). Physiotherapy students were more physically active, smoked less, and consumed fewer sweets and unhealthy snacks compared to nursing students. The authors cited Bandura (1977) and argued that observing is part of the learning process and expressed concern about the suitability of nurses as future role models (Kamwendo et al., 2000). Nursing students ($n=782$) were surveyed in Israel to measure perceptions of smoking prevention (Baron-Epel et al., 2004). Smoking status and students' social environment were found to have a marked influence on students' attitudes to role modelling. The authors argued that nurses who smoke unintentionally affect behaviour of others through behaviour modelling and referenced Bandura's (1977) work. Baron-Epel et al. (2004) made recommendations for a more holistic approach to student nurses' education taking into account social environment. They recommended smoking prevention education to develop positive attitudes for nurses as role models. The authors did not divulge which years of education students were engaged in or consider whether perceptions changed throughout education, which would have added to findings.

Bandura's theory was argued to offer insight to the effectiveness of a teacher who does not model the behaviours they teach (Soeken et al., 1989). Senior USA student nurses completed a preventative lifestyle questionnaire to measure how they engaged in preventative behaviours compared to the general population of same gender and age. Nursing students were less compliant to 12 of 19 preventative behaviours than a national female sample. There was potential for self-reporting bias in this one site study, which is always present in questionnaires, however the questionnaire was previously piloted on

twenty students. Soeken et al., (1989) argued that according to Bandura's social cognitive theory of identification, the observer identifies with and feels that they have more in common with the model, the more likely they are to mimic the modeled behaviour:

“the effectiveness of a model in transmitting knowledge is influenced by similarities in gender, age between the learner and the model, respect for the model and the belief that the model is competent, powerful and attractive” (Soeken et al. 1989: 1031).

A contrasting argument to Merton (1969); discussed in Chapter One; that people compare themselves to groups in which they aspire to belong.

Nurses setting a poor example by smoking can unintentionally have a negative influence on smoking behaviour of others through behaviour modelling (Beletsioti-Stika and Scriven, 2006). Nurses in Greece ($n=402$) were surveyed to compare smoking attitudes, influences on smoking behaviours and desire to quit with motivation to act as health promoters to patients and colleagues. A higher prevalence of smoking was found than in the general population. Participants cited reasons for smoking as enjoyment and a coping mechanism for stress. Paradoxically, most participants perceived they had an important part to play as role models in promoting health behaviour for patients. The strength of the study was data collection across three sites: two civilian and one military to represent different workplaces and policies.

The relevance of self-efficacy to nurses as healthy role models was highlighted in nursing literature. Self-efficacy is the personal belief about capabilities to influence events that affect lives (Bandura, 1994). Self-efficacy beliefs influence how people think, feel, motivate themselves and behave. Bandura (1994) outlined beliefs about self-efficacy as developed through a) mastery experience; building on success, b) vicarious experiences; provided by social models, c) social persuasion; verbal persuasion that they are capable of success and d) reduction of emotional and physical stress reactions; altering negative interpretations of physical state. Blake and Patterson (2015) adapted and used a generalised self-efficacy scale to measure self-efficacy of 67 paediatric nurses; only 16% were found to have high self-efficacy. Nurses are

more likely to undertake healthy behaviours if they have higher levels of self-efficacy (Blake and Patterson, 2015). Bandura's (1994) self-efficacy theory provided a framework for Laschinger and Tresolini (1999) who used The Health Promotion Counselling Self Efficiency Scale (HPCSES) to examine self-efficacy of nursing ($n=41$) and medical students ($n=60$) in health promotion counselling. Self-efficacy scores were high for both groups; nurses were significantly higher on knowledge and ability to counsel patients on exercise, injury prevention and nutrition. Health promotion classroom activities and actual practice were associated with nurses' self-efficacy. Practice, feedback on performance, and role modelling was strongest for medical students in learning about health promotion (Laschinger and Tresolini, 1999). This concurs with Merton's work, which considered the identification of a role model most prevalent in the medical professions. The weakness of this one site study was the small sample size. The site had recently introduced an improved nursing curriculum health promotion input, which may not reflect other curricula.

Chan (2014) considered Bandura's work provided a framework for understanding determinants of health promotion to examine self-efficacy, perceived barriers and benefits to exercise. First year student nurses ($n=195$) in China completed a physical exercise self-efficacy scale and exercise benefits/barriers scale, however participants were from one university site, which limited the generalisability of findings. As opposed to male students, female students did not meet the threshold for physical exercise; identifying fatigue as the greatest barrier to exercise. Male students demonstrated higher self-efficacy. Recommendations were made for educators to improve physical exercise self-efficacy of female students (Chan, 2014).

2.2.2 Theory of cognitive dissonance

The theory of cognitive dissonance was considered relevant to the subject of nurses as healthy role models (Pericas et al., 2009, Blake and Patterson, 2015, Clark et al., 2004). Blake and Patterson (2015) considered paediatric nurses' lifestyle behaviours inconsistent with their concern about population obesity and attitudes towards the importance of role modelling; which they argue is a form of cognitive dissonance. Leon Festinger (1954) explained cognitive

dissonance theory as people having inner drive to keep all attitudes and beliefs in harmony with behaviours and to avoid disharmony (or dissonance). To maintain consistency or harmony (consonance); actions, beliefs, opinions or knowledge are changed. For example, an individual chooses to smoke, they gain knowledge of the dangers of smoking, and this may cause dissonance. To maintain consonance, they have the choice to change actions; cease smoking, or change knowledge and beliefs. While some individuals may choose to cease smoking some may consider or seek other knowledge and beliefs to justify actions. These individuals for example may refer to anecdotal evidence of elderly friends and family who smoked all their lives without harm.

Nursing and physiotherapy students in Spain ($n=345$) completed a recognised WHO survey to assess smoking prevalence (Pericas et al., 2009). Smoking was found to be equal to women in the general population. Non-smokers agreed that health professionals were role models more than smokers. Pericas et al. (2009) argued that cognitive dissonance exists among health professionals who smoke which leads to them underestimating the risks and being less interested in supporting patients to stop smoking. A weakness of this study was the absence of differentiation between physiotherapy and nursing students; as previously discussed there is some evidence that nurses smoke more than physiotherapists (Kamwendo et al., 2000) which could have been considered.

Clark et al. (2004) considered cognitive dissonance a valuable explanatory framework to examine knowledge and attitudes towards smoking of Australian student nurses (Section 1.3). Most participants in the study showed understanding of smoking risks but significant differences were identified based on smoking status. A key finding was the absence of a relationship between knowledge about the effects of smoking and attitudes towards smoking habits. Clarke et al. (2004) argued that findings suggested participants had cognitively isolated knowledge, which did not influence their attitude to smoking. Cognitive dissonance could be considered relevant in other situations where nurses are demonstrated to not apply knowledge to personal lifestyle.

2.2.3 Modeling and Role Modeling (MRM)

MRM is a theory or paradigm of nursing that provides a holistic foundation for practice, education and research (Schultz, 2009). The theory is underpinned by the principle that people have multiple interacting subsystems; biophysical, social, psychological, cognitive, genetic make-up and spiritual drive (Erickson et al., 1983). The theory holds the tenet that stressors in life are a normal part of life; how we react to stressors determines our health. People can be adaptive or maladaptive. Adaptation involves reacting to stressors by mobilising external and internal coping resources without jeopardising any subsystem. Maladaptation is when a person copes with a stressor within one subsystem at the expense of another; one subsystem is jeopardised due to issues in another remaining unresolved. A principle of MRM theory is that people know what makes them sick or what will make them healthy, which Erickson et al. (1983) refer to as self-care knowledge. There are three concepts related to the role of the nurse in MRM. The first concept is the nurse as a facilitator rather than effector. The second; nurturance, suggests that the nurse seeks to understand the clients' perspective; their personal model of the world. The third is unconditional acceptance, which involves the nurse having empathy.

Erickson et al. (1983) provide theoretical statements to describe their paradigm for nursing practice, which emphasises two concepts; modeling and role modeling. Modeling is described as developing an understanding of the clients' world from the clients' perspective, developing a mirror image to put a foot into their foreign world (Erickson et al 1983: 95). Role Modeling is described as:

“the process by which the nurse understands that unique model within the context of scientific theories and, using that same perspective of her client's unique model, plans interventions that promote health” (Erickson et al 1983: 97).

MRM provides five aims for planning interventions with clients; building trust, nurturing self-esteem and hope, promote client control, affirm and promote client strengths and set mutual directed goals.

MRM was mostly unrecognised in the literature relevant to role modelling health promoting behaviour. Three US publications retrieved for this review cited

MRM. The first, (Kinney and Erickson, 1990) which used five case studies to demonstrate how the theory was applied in clinical practice, considered MRM influenced planning individual nursing care. Kinney and Erickson (1990) considered that role modeling is often thought about from the perspective of setting an example or in respect to social learning theory (Bandura, 1977). This implied that MRM may have some relevance to role modelling health promoting behaviour but was not completely consistent with the concept.

MRM was argued to provide a meaningful framework to apply concepts of nurturance and acceptance when planning individualised care (Hagglund, 2009). Application of MRM theory was illustrated using a case study of a woman with a fictitious disorder in a mental health centre. The author of a literature review of hostility in nurses' working environment suggested MRM offered a lens through which to examine hostility in the workplace (Sofhauser, 2015). Using the MRM perspective, nurse-work place hostility was considered the result of unresolved loss, which affected the ability to cope with stressors. Recommendations for practice to address hostility were made using MRM theory such as promoting unconditional acceptance of staff.

The most recent text on MRM (Erickson, 2006) claims that it should be of interest to all health providers interested in integrating, mind, body and spirit within the context of the client's world view. The text presents topics such as energy theories and searching for life purpose. While MRM is inconsistent with the meaning of role modelling health promoting behaviour as implied by the NMC; some semblance of attributes was considered relevant: building trust, nurturing self-esteem and hope, promoting client control, unconditional acceptance and empathy.

2.3 The nurse's role in public health and health promotion.

The manifestation of health and health promotion became integral to nurse education during pre-registration Project 2000 reforms in the 80s (U.K.C.C., 1986). However, there remained some confusion surrounding the understanding of health promotion within the nursing profession. A UK concept analysis of health promotion (Maben and Macleod Clarke, 1995) highlighted

and attempted to address such confusion. However many nurses continued to struggle to explain their understanding, and perceptions often focused on a traditional health education approach (Casey, 2007).

The UK Royal College of Nursing (RCN) document *Going Upstream* (RCN, 2012) examined how nurses could help people become healthier, avoiding illness and premature death, arguing that:

“Nurses are in an ideal position to influence the people they interact with, empowering them to achieve positive public health outcomes”
(RCN 2012:2).

Whilst many nurses work in specific public health roles RCN (2012) guidance outlined that nurses deliver health promoting or public health messages as part of normal care. Patients may be open to messages due to a current health condition suggesting that there are ‘teachable moments’ in such situations (RCN 2012). This theme is supported in government documents that suggest health care professionals should be ‘making every contact count’ (DH, 2012).

Nursing texts consider health promotion and public health integral to any nurses role (Evans et al., 2014). Active involvement by nurses in health promotion has been advocated within UK health policy for over three decades (Holt and Warne, 2007). Holt and Warne (2007) examined second year student nurse evaluations ($n=100$) and conducted focus groups to explore how the UK curriculum has responded to this. Findings suggested a dichotomy between what was taught and the reality of what students’ experience in practice. Holt and Warne (2007) claimed their study was small, however for a qualitative study sample size was reasonable and testing of focus group themes with themes arising from student evaluations, provided some triangulation: a further strength of the study. Holt and Warne (2007) considered that being healthy role models caused dissonance with some students. Participants reported inconsistency between personal lifestyles and professional knowledge. Holt and Warne (2007) discussed an ambiguous conceptualisation of health promotion and health education amongst students and recommended greater curricular emphasis on the nurses’ role in health promotion to prepare them for practice.

UK policy (DH, 2006) views nurses as having a vital role to play in empowering patients as part of health promotion practice. Chambers and Thompson (2008) used qualitative analysis of vignettes to identify which health promotion strategies were offered by UK RNs ($n=20$). Two types of health promotion practitioners were identified: divergent and convergent thinkers. Divergent thinkers adopted a holistic reflexive approach to health promotion, respecting patients' views and understanding the context of patients' lives. Convergent thinkers took a more reductionist, biomedical approach to health promotion emphasising individual behaviour change and control by the nurse (Chambers and Thompson, 2009). Chambers and Thompson (2009) suggested that health promotion was not applied in acute settings because those working in such areas were convergent thinkers. This argument appears to challenge findings discussed in Chapter One ((UNITE), 2002, Jaarsma et al., 2004) that cardiac nurses were good role models. The two studies in question focused purely on physical factors. Considering this in balance with the work of Chambers and Thompson (2009) it can be considered that being a role model is more than physical appearance.

Data analysis from the Global Health Professions Student Survey, which examined tobacco use in nursing, dental, medical or pharmacy schools in 31 countries, found that most healthcare professional (HCP) students considered they have a role to play within society as health promoting role models (Warren et al., 2008). The authors of a more recent study (Ozcakar et al., 2015) examined and compared lifestyle behaviour of nursing and medical students in Turkey; stating that:

“Concerning disease prevention and health promotion issues, health workers bear the responsibility of leading exemplary lifestyles and helping society become conscious of health risks and ways to lead a healthy lifestyle” (Ozcakar et al., 2015: 536).

Student nurses' health was slightly higher than medical students and was argued the consequence of the educational model. The argument was however made unsupported by evidence; the use of the expression “we reckon” (Ozcakar et al., 2015: 540) added little strength to the publication.

Klainin-Yobas et al., (2015) argued that student nurses are expected to act as role model in promoting health. However, using a cross sectional descriptive correlation approach Klainin-Yobas et al. (2015) found students in Thailand had poor to moderate levels of physical fitness. Student nurses ($n=355$) completed physical fitness testing and self-administered questionnaires to measure health behaviours. Cardiovascular fitness and physical flexibility had the lowest scores (Klainin-Yobas et al., 2015). Smoking and alcohol consumption in this cohort was particularly low which may be due to cultural differences. Considering social desirability responses often used in self-reporting surveys, these findings may actually underestimate the reality.

2.4 Exploring perceptions of the link between role modelling and patient behaviours.

Most literature surrounding nurses as healthy role models focuses on observable health such as weight, diet or smoking and perceptions about whether this has the potential to impact on patients' behaviours. The weight of a professional is argued to affect the likelihood of whether the public listen to lifestyle health advice, particularly in reference to diet and exercise (RSPH, 2014). Research conducted by the Royal Society for Public Health randomly sampled 2100 UK adults who completed an online survey. This was an unpublished study and findings were summarised briefly in a press release (RSPH 2014):

- 9% would take diet and exercise advice from an overweight GP, however, 59% would take advice from a GP of healthy weight
- 41% are less likely to take advice on diet and exercise from an overweight or obese healthcare professional, than would take their advice (17%) (RSPH, 2014)

Public Health England chief executive stated that from the findings of the study:

“It is clear that the public are more inclined to take advice from those of us who are a healthy weight. Healthcare professionals and the wider public health workforce are going to be instrumental in supporting the two thirds of us who are either overweight or obese to lose weight, so it is useful to know what might help or hinder in

getting healthy lifestyle messages across to the public. It appears that healthcare professionals need to be role models in order to help convince the public of the importance of losing weight.” (RSPH 2014).

However, when considering the weight of this evidence, it should be recognised that an online poll approach was used, unsupported by a theoretical methodology. Populus a human resource research and consulting company, conducted the survey. A full copy of data was requested, obtained and reviewed for this thesis. One question focused on nurses specifically: respondents were 51% less likely to take advice on diet and exercise from an overweight nurse, in contrast to 5% who were more likely to take advice. However, 43% considered it made no difference either way. The RSPH press release summary of findings about overweight or obese HCP’s omitted findings that 41% felt it made no difference either way. This survey provided some evidence of indifference in respondents to a nurse or other HCPs’ body weight when receiving advice.

Hicks et al. (2008) evaluated whether nurses’ weight influenced general public confidence in the nurses’ ability to provide health education. Participants ($n=71$) were randomly selected and shown images of either an overweight or weight appropriate nurse. They marked a ten centimetre visual analogue scale of how confident they would feel about diet and exercise advice being provided by each nurse. Healthy weight nurses were shown to inspire higher levels of confidence in teaching and health promotion advice than overweight nurses (Hicks et al., 2008). Although a small-scale study, it was a replication study of previously unpublished work. One small study cannot claim that observable healthy lifestyles of nurses can impact on promoting population health overall but the study approach was feasible and replicable; presenting some preliminary evidence. Limitations of the study were lack of participant demographic detail; ethnicity was not recorded and cultures have a varied perception of weight. Some participants asked the qualifications of each nurse which suggests that they would consider others factor than weight relevant.

Some RNs perceive that patients have more confidence in receiving health promotion advice from a nurse who appears to follow it themselves (Blake and Patterson, 2015). Blake and Patterson (2015) focused on paediatric nurses' attitudes to the promotion of healthy eating. As previously discussed (Sections 1.3 & 2.2.1), questionnaires were used to assess fruit and vegetable consumption, physical activity and self-efficacy. Questionnaires, designed in collaboration with nurse educators, included eleven statements to assess attitudes as role models for health promotion for healthy eating. Participants ($n=67$) responded to each statement on a 5-point Likert scale: 77% of participants felt those in their care would heed advice more if the nurse followed their own advice. Response rate for this study was very low (23%). Although Blake and Patterson (2015) considered the sample representative of the hospital trust it is possible that respondents had a prior interest in healthy eating. Whilst this might suggest reports of negative health behaviours are underestimated, agreement with being healthy role models may be overestimated. Participants (48%) claimed to have difficulties in promoting health behaviours they did not follow themselves (Blake and Patterson, 2015). This later finding is corroborated by findings in a US study (Esposito and Fitzpatrick, 2011) of RNs ($n=112$). The correlation descriptive study utilised a health-promoting lifestyles scale, an exercise benefits/barriers scale and a scale measurement response to two statements of recommendations made to patients about exercise. Nurses who believed in health promotion and had healthy exercise behaviours were found more likely to teach healthy behaviours to patients and act as role models.

Rush et al. (2010) developed a measurement scale, described as a first-generation instrument and the first known measure of nurses' self-perceptions as health-promoting role models. Rush et al. (2010) argued the *Self as Role Model for Health Promotion (SARMHEP)* tool as useful for practitioners to monitor effectiveness as health promoting role models. The 57-item, five factor scale was developed using theoretical schema from literature, exploratory factor analysis and previous qualitative work of Rush et al. (2005b). Factors involved: 1) use of professional self, 2) identification of self with idealised image, 3) use of imperfect self, 4) valuing self and 5) self as health promoter. Use of

imperfect self; the result of prior work by Rush et al. (2005b), will be expanded upon in the next Section.

A recent literature review of forty-seven articles, conducted by Lobelo and De Quevedo (2016), also considered perceptions of the link between role modelling and patients' behaviours and reported an association between Health Care Professionals' (HCP's) personal physical exercise habits and counseling practices. Physically active HCPs were found more likely to provide counselling on physical activity to patients and "can indeed be powerful role models" (Lobelo and De Quevedo, 2016: 36). Although most of the studies in the literature review focused on physicians, nine included other HCPs including nurses. This review focused on physical activity in isolation but demonstrated a correlation between HCPs' personal habits, the way they counselled patients, and the influence they had as role models.

2.5 Nurses' views of being healthy role models

Nurses have negative and positive views about being a role model dependant on the meaning they give the term role model (Rush et al., 2005b). Focus groups and in depth interviews were used to explore how RNs described themselves as health promoting role models. Eleven nurses participated in focus groups and four nurses were interviewed. For some an idealised role seemed unrealistic, which conveyed a false reality while others felt it represented something to aspire to. Some conveyed a humanistic understanding that nurses and patients struggled with the same health promoting goals and flaws could motivate behaviour change in others. The requirement to role model made some nurses feel threatened; for some it created a discomfort by inconsistency between what they teach and what they do (Rush et al., 2005b). There was minimal variability in the sample of the study regarding race and gender and sample size was small. A further limitation was the lack of student nurses in the sample group who could have provided valuable data.

Many nurses feel they should be healthy role models (Sarna et al., 2016, Ordas et al., 2015, Blake and Patterson, 2015, Blake and Harrison, 2013, Moxham et

al., 2013). Blake and Harrison (2013) investigated whether UK pre-registered nurses ($n=540$) considered they should be healthy role models using ten statements to assess attitudes towards being a role model. Participants answered using a five point Likert scale and over two thirds agreed with statements that nurses should practice what they preach, present themselves as role models and role modelling was important to their role. Opinions varied according to weight classification: overweight or obese participants were statistically significantly less likely to agree which suggested that opinions about being healthy role models are influenced by weight. Statements from Blake and Harrison (2013) study were adapted and later contributed to the study of Blake and Patterson (2015) who reported that 84% of participants agreed with the statement '*paediatric nurses should present themselves as role models for health*'.

Nurses as healthy role models was debated at a UK national forum; the Royal College of Nursing National Congress, entitled: "Do we practice what we preach?" (RCN, 2008). Delegates considered they should have the right to choose how they live their lives and asked that nurses not be turned into '*health gods*'. These conference proceedings only represent the views of those delegates who vocalised their opinions, however they do highlight the concerns of some nurses at the time. The speaker claimed research was required to identify reasons behind nurses' unhealthy lifestyles.

Most publications about nurses' views of being healthy role models focus on weight or smoking. Smoking status influenced views on being role models (Slater et al., 2006) of RNs ($n=1199$) in Northern Ireland who completed a multiple choice and Likert style questionnaire, which examined smoking behaviour related to cessation practice. Although not identified as an aim of the study, three statements measured nurses' opinions of being non-smoking exemplars. Participants were categorised as smokers, ex-smokers and non-smokers. While most agreed they should be exemplars, smokers rated it lower than non-smokers. Diverse participant work environments across community and acute settings, nursing homes and voluntary organisations were a strength of this study.

International publications provided evidence of nurses' views toward being healthy role models. RNs ($n=2440$) in China completed a web based survey to assess behaviours and attitudes to smoking (Sarna et al., 2016): 88.5% of participants scored 4 or 5 on a Likert scale in agreement to being smoke free role models. The strength of the study was scale, conducted across two cities. However, the low response rate (24%) in one city affects generalisability of findings. Ordas et al (2015) conducted a sequential cross sectional study in Spain to assess prevalence, knowledge, beliefs and attitudes towards smoking in undergraduate nursing and physiotherapy students ($n=812$). Key findings from questionnaires included a decrease in prevalence of smoking over a ten-year period, similar to general population and lack of awareness of the relationship between tobacco smoke and health problems. Most agreed they should set a good example by not smoking which the authors interpreted as participants recognising that they should be role models (Ordas et al., 2015). Recruiting participants during classroom time achieved a high response rate, however no ethical consideration was provided to demonstrate avoidance of coercion. Reliability of study results was potentially influenced by social desirability responses of self-reporting questionnaires. Findings only reflected three snapshot occasions over a ten-year period when questionnaires were administered. A further limitation was absence of differentiation between nursing and physiotherapy students. As identified previously in this chapter, there is some evidence that physiotherapy students adhere to healthy lifestyles more than nursing students (Kamwendo et al., 2000).

Student and graduate nurses ($n=217$) were surveyed for knowledge and attitudes toward smoking cessation in Australia (Moxham et al., 2013). The authors of the descriptive study argued it:

“adds evidence to the growing body of knowledge that there is a link between behaviours, attitude and beliefs of clinicians regarding smoking cessation and their duty as role models and agents of change towards their patients” (Moxham et al., 2013: 1146).

The link is tenuous, as factors analysis of the descriptive questionnaires did not include the term role model but *‘nurses should promote a healthy lifestyle’* or *‘should be non-smokers’*.

DeMello et al. (1989) reported US nurses' views of being healthy role models. The quantitative study used questionnaires to assess prevalence of smoking and attitudes towards the exemplar role. In response to the statement that they *'should set a good example by not smoking cigarettes'*, 92.6% pulmonary clinical nurse specialists agreed, 100% oncology nurse specialists, 72.4% critical care nurses and 75.9% medical and surgical nurses. Critical care nurses had the highest prevalence of smoking and oncology nurses the lowest, which suggests that smoking behaviour influenced views surrounding healthy role modeling.

2.6. Perceived barriers and facilitators to nurses being healthy role models

Within the literature, barriers and facilitators to nurses acting as role models were explored across different papers. These included barriers and facilitators linked to pre-registration education, organisational barriers, and a nurse's own poor health or health behaviour which is observable to others. Evidence and debate within each category will be discussed in turn. Many publications identifying barriers to nurses being role models also present some solutions.

2.6.1 Pre-Registration education

Transferring knowledge gained about health during education to personal lifestyles was considered important to nurses becoming role models within the literature; however barriers were also identified, which are included in this section. Blake et al. (2011) conducted a cross sectional questionnaire survey demonstrating the poor health of student nurses; more than half of the 325 participants did not meet physical exercise recommendations. Lack of transferring knowledge gained about physical exercise to personal lifestyle was caused by barriers such as: lack of time, cost, tiredness and lack of motivation. Blake et al. (2011) argued that barriers should be addressed for nurses to be role models in physical exercise and suggested physical activity programmes, sports tournaments and cycle to work schemes. The overall poor health profile of pre-registered nurses needs to be addressed by early education; improving and maintaining personal health and interventions should be targeted to raise awareness about the role as exemplars in healthy lifestyle choices (Blake et al.,

2011).

Malik et.al. (2011), previously discussed in Section 1.3, also considered the issue of knowledge gained about the positive impact of physical exercise, not being transferred to personal behaviours. This was argued to be caused by certain barriers such as lack of time due to long working hours, shift work, lack of motivation and monetary problems. Malik et. al. (2011) suggested that tailored lifestyle programmes during education would:

“not only allow them to be optimal role models for their patients once qualified, but may also help them to cope with the stresses of the nursing profession” (Malik et.al., 2011: 494).

Roux et al. (2014) conducted a feasibility study to assess a *Healthy Nurse*, nutrition and exercise programme introduced to the curricula, “as healthy nurses are role models for a healthy nation” (Roux et al., 2014: 49). Barriers to student nurses maintaining nutritional targets were identified as stress of exams resulting in lack of sleep and night snacking. Academic workload, long days or shift work were identified as barriers to exercise. The programme, which was evaluated by Roux et al (2014) at a US nursing college, included hourly sessions for six weeks for students to consider personal behaviour change goals. Pre and post testing of BMI and body measurement was conducted; no significant difference was evident in the post test BMI but a significant ($p=.06$) difference was recorded in thigh measurement. Integrating an educational nutritional and exercise programme into the curriculum was argued by Roux et al. (2014) to support healthy behaviour change in student nurses despite the lack of positive change over six weeks; subsequently an eight-week programme was developed. Such a programme supports individuals on a personal level but does little to address the identified work environment barriers. Roux et al., (2014) demonstrated some impact of a six-week intervention in isolation but did not consider integrating similar interventions throughout a three-year course or lengthening the programme beyond eight weeks.

Yeh et al (2005) identified that an educational lifestyle-programme supported behaviour change in student nurses and demonstrated a positive change in exercise, physical fitness and nutrition. They concluded that:

“With innovative classroom experiences, future nurses can be healthier, engage in more positive lifestyle behaviours, and serve as health promotion role models for the entire population” (Yeh et al., 2005).

The ten-week healthy lifestyle-promoting programme was piloted in Taiwan (Yeh et al., 2005), commencing with a two-hour introduction to the components of healthy lifestyles: exercise, nutrition, stress management, recreation, health responsibility and social support. Students kept self-evaluation diaries, and health promotion plans. Access to an instructor was available throughout the programme. Pre and post measurements included: weight, body fat, waist to hip ratio, flexibility, physical fitness, muscle strength and cardio respiratory endurance. Healthy lifestyle was assessed using a validated Health Promotion Lifestyle Profile (HPLP): a 4-point Likert scale to score 42 positive and negative health actions or perceptions. This study provided statistically significant evidence of positive health change, however it lacked a control group. Participants were senior students taking part in a community health-nursing course and therefore were not representative of all student nurses.

Stressors for student nurses were previously identified as assessments, studies and finances in Section 1.3. Nurturing and supporting mental health should address such barriers, to prepare student nurses as healthy role models (Timmins et al., 2011). Shriver and Scott-Stiles (2000) conducted a longitudinal study of health habits of USA student nurses and identified facilitators within the curriculum to support nurses becoming role models which involved other approaches than lifestyle programmes. Seventy-one nursing students were compared to 83 other students to assess improvement in positive health behaviour over two years. Nursing students improved in health significantly; facilitators within the curriculum were identified: 1) learning about being a good role model for patients, 2) learning about disease processes, 3) being influenced by providing patient education, gaining self-awareness through curricular activities and 5) learning about the need to live healthily now rather than later; prevention rather than cure. Limitations of the study (Shriver and Scott-Stiles, 2000) included selection bias; a convenience sample provided

difference in gender and age between the two groups.

Overall publications identifying barriers to nurses becoming role models, such as stress, financial issues, lack of time or long working hours within pre-registration education, mostly considered the solution as being to introduce lifestyle programmes into the curriculum (Malik et al., 2011, Roux et al., 2014, Yeh et al., 2005). There appears to be some evidence that this may offer a solution but further research is needed.

2.6.2 Organisational

Organisational barriers to nurses being healthy role models identified in the literature included lack of organisational support, shift work, lack of time and stress. An anthropometric measurement and self-administered survey of 194 nurses from six US hospitals took place across a diverse range of clinical areas. BMI recordings indicated that 28% were classified obese and 37% overweight. These findings were more reliable as they were based on physiological measurements rather than self-reporting alone. Zapka et al. (2009) argued that given the role of the nursing profession, as role models to patients, family and community, work environments should address obesity prevention. Levels of overweight and obesity were similar in the general population, however, Zapka et al. (2009) argued the importance of improving activity and eating behaviours in nurses to create a '*pool of health role models*'. Participants rated organisational support to health as modest and 80-81% of participants reported their work environment as stressful. These barriers could be addressed by work place initiatives such as reassessing staffing patterns and ratios, to enable adequate breaks and policies to prohibit nurses eating unhealthy food in the view of patients (Zapka et al., 2009). A systems approach to obesity management was described as workplace fitness facilities, available healthy food and snacks. Incentives for camaraderie and team weight loss were recommended. The authors argued that to facilitate nurses' potential as healthy role models "a better understanding of nurses' weight and work is important" (Zapka et al., 2009: 857). Risk of selection bias was considered in this study; the response rate was 54.5% and reasons for refusal included: not being interested, lack of time or conflicting demands. Zapka et al., 2009 suggested a

solution as being to promote a favourable climate to improve nurses' health habits through supporting healthy lifestyle choices:

“while many weight and lifestyle interventions emphasise an individual focus, system level innovations are key” (Zapka et al., 2009: 858).

Perry et al. (2014) identified risky alcohol intake in female nurses under 35 years old and identified a correlation between length of shift and increased alcohol consumption. Factors that have a negative influence on the health of nurses affects their credibility as role models (Perry et al., 2015). Almajwal (2015) identified shift work as a barrier to physical exercise in non-Saudi Arabian nurses in Saudi Arabia ($n=365$). Participants (46.7%) who worked shift duty and night shifts had higher BMI's than day shift nurses. Barriers to physical activity were recorded: weather, lack of transportation, time, facilities and motivation (Almajwal, 2015). The geographical area of this study explained weather and transportation, which reduced the generalisability of the findings. Time, facilities and motivation as barriers to nurses as health role models do however concur with other studies. (Malik et al., 2011, Blake et al., 2011).

Overall, shift work, lack of time and stress were identified within the literature as barriers to nurses as healthy role healthy models. An organisational systems approach rather than individual approach was suggested as key to addressing such barriers.

2.6.3 Observable behaviours

Predominantly within the literature, observable behaviours such as being seen smoking, eating well or exercising were considered relevant to a nurse's ability to be a healthy role model. Smoking, physical image, weight and smoking were all identified as barriers to being a good role model. (Chalmers et al., 2003, Moxham et al., 2013, Beletsioti-Stika and Scriven, 2006, Dao Thi Minh et al., 2008). Chalmers et al. (2003) used a mixed methods approach of surveys, interviews and class forums, to examine perspectives of smoking habits of 272 Canadian student nurses. Participants were aware of the need to portray themselves in a healthy way, however some smokers felt they were hypocrites and had nothing to offer. Students reported RNs in practice settings did not offer

advice on smoking cessation and often smoked, which they considered a barrier to being a good role model. Participants considered academic staff smoking a barrier to them being good role models to students. The self-reporting nature of smoking rates might indicate an underestimation due to social desirability bias. Furthermore, the nature of the study may have deterred smokers from volunteering (69% response rate): 48.2% reported to have never smoked, 24.6% had experimented, 5.1% had ceased, 9.2% were social smokers and 12.9% smoked. Chalmers et al. (2003) argued that facilitating students to become role models in health promotion requires providing opportunities to discuss their role in health promotion within the classroom. Being seen smoking in uniform was considered a barrier to being a good role model by pre-registered nurses in one UK university (Blake and Harrison, 2013). Weight, physical appearance and image were also considered important to be role models for healthy behaviour.

Blake and Patterson (2015) identified barriers and facilitators for promoting healthy eating and examined attitudes of paediatric nurses as role models for health behaviours. Barriers included: lack of knowledge and training, shift patterns/tiredness, lack of personal confidence, lack of healthy food in the hospital, negative values and attitudes and not perceiving it to be part of the nurses' role. Participants (70%) considered healthy diet and regular exercise necessary to their role. The nurse being a 'visibly' good role model (healthy weight) was identified as a facilitator to promoting healthy eating to children. Examples of other facilitators to being a healthy role model included: good relationships with patients, nursing being a respected profession, personal confidence, having appropriate information, healthy menu options in hospitals, personal motivation to promote health and support from others. Barriers and facilitators to promoting health eating cannot be generalised to being healthy role models, however the link between promoting healthy eating and being healthy role models provided by Blake and Patterson (2015) provides considerable insight.

2.7 Summary

Relevant theoretical frameworks have been identified and explained in this chapter. Modeling and Role Modeling (MRM) provided some relevance but was discussed as removed from the meaning of role modelling health promoting behaviour as implied by the NMC. Social cognitive or learning theory was considered very relevant; linked to nurses being more likely to undertake healthy behaviours if they have higher levels of self-efficacy. The theory of cognitive dissonance was considered relevant to nurses as healthy role models and suggested to provide insight to instances when nurses do not apply knowledge surrounding healthy promoting behaviour to personal habits. The nurses' role in public health and health promotion was considered from a professional and policy perspective. Promoting health or public health messages as part of normal care was discussed as empowering people to achieve positive health outcomes. Critical consideration was given to existing evidence of efficacy of nurses as healthy role models. Almost half of the respondents in a UK public poll, considered that weight of a nurse made little difference to confidence in the advice provided. Negative and positive views to being a role model were identified within the literature and overall most nurses appear to agree they should be healthy role models although opinions can be influenced by weight or smoking status.

Critical review of literature further highlighted issues surrounding the health of nurses and the existing gap in knowledge of how UK nurses define the concept of role modelling. Evidence from the studies reviewed suggest that it is timely to provide deeper understanding of what the term role modelling health promoting behaviour means to the nursing profession and to further explore nurses' attitudes to being healthy role models.

Chapter 3: Methodology and data analysis

3.1 Introduction

This chapter outlines the epistemological stance and research design for the thesis and describes the methodological framework. The methodology was developed to support the overall aims and objectives discussed in the previous chapter: a Hybrid Concept Analysis and Development approach. Consideration is given to the background of concept analysis and development. Strengths and limitations of concept analysis approaches are discussed and a detailed outline provided of the three-phase hybrid approach used for this research study. Data collection and analysis methods are described for the theoretical, fieldwork and final analytical phases of the study. Trustworthiness of the qualitative research is considered including self- reflexivity of the researcher. Finally, consideration is given to ethical issues.

3.2 Ontology and Epistemology

Epistemology is how we come to know something (Kraus, 2005) and the epistemological stance of this research was interpretivism. This approach was applied through exploring nurses' perceptions about what being a role model in health promoting behaviour actually means to them thorough interpretation of literature and qualitative data. Interpreting nurses' experiences of healthy role modelling in practice provided understanding of the context, thus grasping meaning of social action (Bryman, 2012).

Ontological considerations involve the philosophy of what we know (Bryman, 2012) and the ontological foundation for this study was social constructivism. The tenets of social constructivism provided a foundation to delve beyond literature and provide deeper understanding of nurses as healthy role models by taking into account differing values, beliefs, backgrounds and roles in society in an ever-changing environment of health care. Taking a constructivist view of the world that knowledge and truth is constructed by individuals, included taking a critical stance of taken for granted approaches of understanding the world to explore what meaning nurses gave to being healthy role models, drawing on

their experience in practise. Knowledge and meaning is constructed by social action and interaction, it is historically and culturally specific and often bound with power relations (Burr, 2003). The NMC requirement takes for granted nurses' understanding of the concept of role models in health promoting behaviour and this research took a critical stance by exploring understanding and attitudes in both literature and qualitative data.

3.3 Concept Analysis and Development

A concept analysis approach was chosen for this study as it enables the researcher to “come to grips with the various possibilities within the concept of interest-to “get inside” the concept and see how it works” (Walker and Avant 2014: 163). Everyday concepts are a cognitive formation resulting from natural human processes, which occur by being in the world with others (Penrod and Hupcey, 1998). Concepts are the *building blocks* of theory construction; the function of concept analysis is to examine function and structure of the building blocks (Walker and Avant, 2014). Many published concept analyses do not explore beyond the literature (Lobo et al., 2013, Lebel et al., 2014, McLeod-Sordjan, 2013). Numerous approaches to concept analysis and concept development have evolved from the primary Wilsonian (1963) technique developed in the 1960's. Four approaches to concept analysis will firstly be described in this Section, strengths and weaknesses will be summarised briefly in Table 3.4 before being fully considered in Section 3.4.

Wilsonian Method

Wilson's original model was considered a classical method for concept analysis (Toftthagen and Fagerstrom, 2010) which influenced subsequent methodological development. Wilson (1963) advocated eleven stages, or steps; isolating questions of concept, finding right answers, identifying model, contrary, related, borderline and invented cases, social context, underlying anxiety, practical results and results in language. The first step involves asking what are the known facts about the concept. The second step, finding right answers, means finding best use of the concept in the context in which it is being explored. A model case, an example from the data, demonstrates all

defining attributes. A borderline case is an example demonstrating most of the defining attributes. Related cases are examples that relate to the concept in some way but do not include all attributes. Contrary cases provide an example of 'not the concept'. Wilson considered awareness and sensitivity of the researcher to essential (model cases) and non-essential (borderline, related cases) elements of the concept, contributed to successful concept analysis. Step eight identifying social context involves considering who uses the concept and in which environment and expiating underlying feelings of anxiety was recommended as the ninth step. Step ten involves identifying results brought about by the concepts essential elements and understanding how the concept is used in practise before finally (step 11) defining the concept by identifying the best meaning.

Wilson suggested sequential steps and advised that the last four steps might be irrelevant to some concepts. Wilson's traditional approach was intended for use by sixth form students in the classroom and was considered simple yet achievable by some (Avant, 2000). Wilson's approach included deductive searching of data to identifying social context (Step 8), which provides consideration of contextual issues. Such a reductionalist, deductive approach overlooks other contextual influences "such as political, financial or historical" (Beckwith et al., 2008: 1836).

Walker and Avants' strategy

Wilson's approach was adapted in the 1980's by Walker and Avant (1983) and was reduced from eleven to eight steps as outlined in Table 3.1. Walker and Avant claim to have simplified Wilson's approach and consider: "eight steps are sufficient to capture the essence of the process" (Walker and Avant 2014: 165).

Table 3.1: Steps of conducting concept analysis

Wilson (1963)	Walker and Avant (2014)
1. Isolating questions of concept	1. Select a concept
2. Finding right answers	2. Determine the aims or purposes of analysis
3. Identifying model cases	3. Identify all uses of the concept that you can discover
4. Identifying contrary cases	4. Determine the defining attributes
5. Identifying related cases	5. Identify a model case
6. Identifying borderline cases	6. Identify borderline, related, contrary, invented and illegitimate cases
7. Identifying invented cases	7. Identify antecedents and consequences
8. Identifying social context	8. Define empirical referents
9. Identifying underlying anxiety	
10. Identifying practical results	
11. Identifying results in language	

In practice Walker and Avant extended rather than simplified Wilson's original approach by condensing some steps within a common descriptor and introducing three steps: identifying defining attributes, antecedents and empirical referents. Walker and Avant consider defining attributes necessary to allow the researcher to decide which phenomena fit the concept or which do not, they are defining characteristics always present in the concept and should bring the concept to mind. Identification of empirical referents is argued by Walker as Avant (2014) to contribute to theoretical development of a concept by identifying measurable ways to demonstrate the occurrence of a concept. Defining attributes and empirical referents can often be identical but empirical referents relate to defining attributes rather than the entire concept, examples are provided in Table 3.2. Walker and Avant consider identifying antecedents useful to identify underlying assumptions of a concept and explain that antecedents vary from defining attributes; they are the things that must be in existence before the concept can occur and are. Identifying consequences

therefore providing context (Walker and Avant 2014). A further contrast in the two approaches is Walker and Avant (2014) recommend iterative steps, which they consider leads to a more precise analysis whereas Wilson (1963) recommended sequential steps.

Similarities to Wilson's approach include step 6, identifying borderline, related, contrary, invented and illegitimate cases, which Wilson identified as separate steps. Identifying consequences of a concept (the result of the concept) is included in step 7 by Walker and Avant and argued to capture ideas and relationships surrounding a concept, which is similar to Wilson's step of identifying practical results. Examples of attributes, antecedents, consequences and empirical referents, retrieved from published concept analyses are illustrated in Table 3.2

Table 3.2: Examples from published concept analyses

Author	Concept	Example
(Maben and Macleod Clarke, 1995)	Health promotion	Attribute Marketing and selling of health
(Lobo et al., 2013).	Nursing overtime	Antecedent Shrinking nursing workforce
(McLeod-Sordjan, 2013)	Death preparedness	Consequence Improved quality of death and dignity
(Lebel et al., 2014)	Physiological stability	Empirical referent Maintenance of physiological parameters

Walker and Avant acknowledge their methods are often critiqued for being too simplistic and not allowing the researcher to “ground the concept within its

context” (Walker and Avant 2014:179). The approach has been critiqued for lacking rigour, as it does not include a review strategy or critical appraisal of retrieved literature (Lebel et al., 2014, Lobo et al., 2013, Draper, 2014). Lobo et al. (2013) considered the approach basic and lacking in procedural explication, which they considered made tracking and analysis of large volumes of literature difficult. Furthermore, Lebel et al. (2014) considered the lack of literature review strategy a limitation when using the approach and reflected that an alternative approach might have allowed further knowledge development to their published concept analysis.

A hybrid approach

In the 1980’s a hybrid concept development model was developed (Schwartz-Barcott and Kim, 1986) to identify, analyse and refine concepts which acknowledged previous work of Wilson and Walker and Avant. However, in contrast to Walker and Avant, Schwartz-Barcott and Kim did not include identifying antecedents, defining attributes and consequences empirical referents in their approach. The hybrid model outlined three phases: theoretical, fieldwork and final analytical. The theoretical phase involves selecting a concept, searching literature and considering various meanings of the concept to arrive at a working definition with which to begin fieldwork. The fieldwork phase aims to corroborate and refine the concept by extending and integrating analysis with empirical observations. The final analytical phase involves weighing, working and writing up the findings in light of the initial focus of interest and includes the researcher considering: i) the relevance of the concept, ii) if the selection of the concept seems justified, and iii) to what extent the theoretical and empirical analysis support the presence and frequency of the concept within the population under study (Schwartz-Barcott and Kim, 2000). The hybrid model has been used for concept analysis of nurses’ identification of pain in patients with dementia (Chang et al., 2011) and found useful to clarify and specify meaning found in the literature with qualitative findings from In-depth interviews.

Rodgers evolutionary approach

A further approach to concept analysis, the “evolutionary view” was suggested in the late eighties (Rodgers, 1989). The evolutionary view works on the premise that concepts develop or evolve over time; influenced by the context in which they are used, which is consistent with social constructivism. Primary iterative activities, which are illustrated in Table 3.3, represent tasks to be accomplished rather than formal steps.

Table 3.3: Rodgers’ evolutionary approach

Rodgers activities
1. Identify the concept of interest and associated expressions
2. Identify and select appropriate realm (setting and sample)
3. Collect data to identify attributes and contextual basis of concept: antecedents and consequences and
4. Analyse data regarding the above characteristics
5. Identify an exemplar of the concept
6. Identify implications, hypotheses and implications for further development of the concept

Rodgers (2000a) disagreed with both Wilson and Walker and Avant about identifying and separating out related cases, because she considered subjectivity of the researcher could introduce an element of bias. A further contrast to Wilson and Walker and Avant was the structured guidelines for literature searching. Rodgers (2000a) considered that no researcher could identify the entire population of relevant literature and recommended stratified systematic sampling of all indexed literature, using a random starting point. Rodgers suggested 20% of the total literature or 30 items from each discipline for analysis was appropriate for analysis. However, Rodgers acknowledged a limitation to the approach was the overlap among disciplines and the large volume of literature, which is very costly and time consuming. This may explain why the number of disciplines and references provided for published concept analysis using Rodgers approach vary from one to ninety seven (Tofthagen and

Fagerstrom, 2010). Analysis of videos and images is considered relevant to this approach, which includes thematic analysis of qualitative data to integrate with literature, to add to depth of understanding.

3.4.1 Methodology for the present research

The strengths and weaknesses of presented approaches to concept analysis and are summarised in Table 3.4 were considered for use for the present research. Wilson's approach was considered too simple and reductionalist to analyse the concept nurses as role models in health promoting behaviour because of its sole focus on literature (dictionaries, thesaurus, scientific and ordinary) for data analysis; this was also considered a limitation of Walker and Avant's approach. Although Wilson suggested identifying the social context, underlying anxieties and practical results of the concept, a more inductive approach to analysing data was sought for the present study. Furthermore, over reliance on case reconstruction in Wilson's approach raised concerns that understanding would be reliant on precedents of cases sourced in literature, rather than applying understanding to identify real life cases if possible. Wilson's method was therefore rejected because it was not considered adequate for publishable standard research due to its sole focus on literature and because greater depth was sought to address the research aims and objectives of this thesis. Aspects of Walker and Avant's approach were however considered useful to address the research aims and objectives of this doctoral research, which are outlined in Section 3.4, e.g. defining attributes, antecedents, consequences and empirical referents.

Table 3.4: Strengths and weaknesses of approaches to concept analysis

Approach to concept analysis	Strengths	Weaknesses
Wilson	Identifying model cases, contrary cases, related cases, borderline cases captures essential and non-essential elements of the concept	Deductive and reductionalist- lacking depth and interpretation
Walker and Avant	Defining attributes, antecedents, consequences and empirical referents- adds to understanding of concept	Deductive and reductionalist- as above Lack of literature review strategy and critical appraisal- lacking scholarly rigour
Schwartz-Barcott & Kim	Flexibility Detailed analysis of fieldwork to provide deeper understanding Integration of literature and qualitative data in a final analytical phase provides triangulation Provides guidance on writing up as last step	Does not identify defining attributes, antecedents, consequences and empirical referents, which lacks contextual consideration.
Rodgers	Structured framework. Noting instances of concept in literature- suggests relevance. Inclusion of thematic analysis of data- adds to depth of understanding	Researchers construction of a model case may be influenced by subjective assumptions Time consuming expensive search strategy. Does not suggest related case which may add to understanding of concept by capturing non-essential elements of the concept

Rodgers' approach offered the opportunity to incorporate empirical evidence through the collection and thematic analysis of qualitative data, which was considered essential to capture experiences and perceptions of nurses as role models in health-promoting behaviour. Rodgers also suggested noting and recording instances of the concept; in this case 'role model in health promoting behaviour', in the retrieved publications. Although some consider the recording of instances not helpful as it does not interpret or appreciate context (Beckwith et al., 2008), it offered a technique to assess and record the relevance of each publication to the concept under examination, which other approaches did not. However, adopting Rodgers' approach in totality was rejected due to the time consuming a costly strategy for retrieving literature, which results in large volumes of multi-disciplinary literature. The hybrid model offered a structure to the research process but did not suggest identifying antecedents, defining attributes and consequences empirical referents, which were considered useful for contextual consideration of nurses as healthy role models.

Published concept analyses are criticised as lacking scholarly rigour and empirical enquiry (Botes, 2002, Draper, 2014, Penrod and Hupcey, 1998, Beckwith et al., 2008). Many concept analyses are considered no more than "low-grade literature reviews" (Draper 2014: 1208). Adapting a hybrid approach to analyse the concept of nurses as role models in health promoting behaviour was considered to surpass previous published concept analyses. Rodgers (2000b) recognised that Schwartz-Barcott & Kim (1986) had made a significant methodological advancement by developing a hybrid method, and suggested that rather than simply using existing methods to analyse and develop concepts, researchers formulate new approaches to serve them best. Developing new approaches can provide a broader focus of enquiry to advance knowledge (Rodgers 2000b) and provided an opportunity to be innovative with methods to best suit research questions of a study (Botes, 2002). Following on from this recommendation an adapted hybrid approach was developed to answer the research questions for the present thesis. The approach was designed to include:

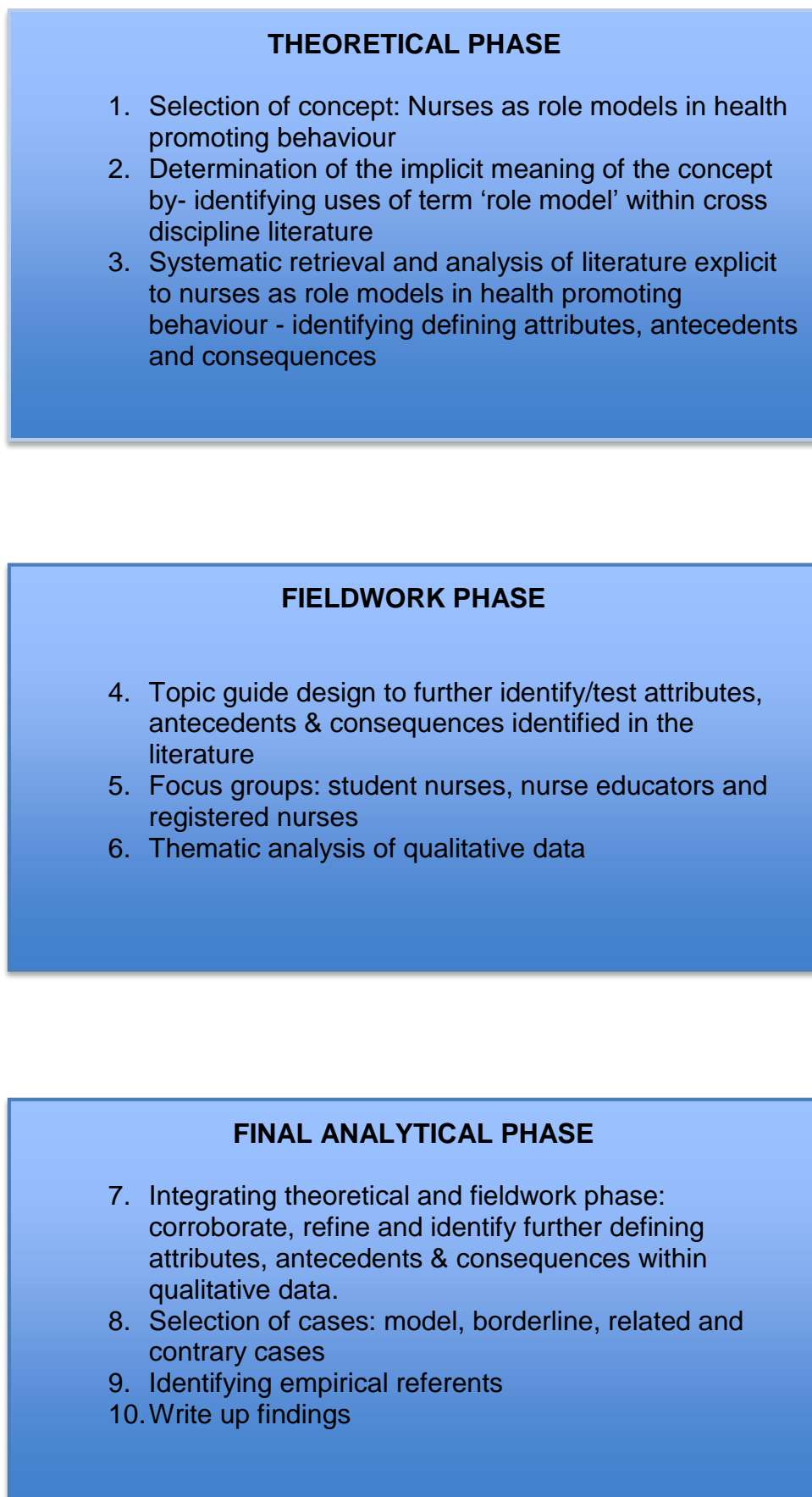
- Three clearly defined phases, which offered structure to the research process: 1) theoretical phase 2) fieldwork phase and 3) final analytical

phase. Theoretical findings provided a foundation from which to conduct the fieldwork phase as recommended by Schwartz-Barcott and Kim.

- Determining uses of the concept across disciplines as recommended by Walker and Avant and Schwartz-Barcott and Kim.
- Identifying antecedents, attributes and consequences in specific literature as recommended by Walker and Avant.
- A qualitative study with RNs, student nurses and nurse educators to provide data (through thematic analysis) to contribute to identifying antecedents, attributes and consequences as recommended by Rodger's.

The methodological framework for the present study is illustrated in Figure 3.1.

Figure 3.1: Methodological Framework



3.4.2 Investigating student nurses, nurse educators and registered nurses' experiences

To meet the broad aims of the present study to investigate student nurses, nurse educators and registered nurses' experiences and perceptions of role modelling health-promoting behaviour data from all groups were analysed together. Consideration was given to whether opinions and experiences within these groups would vary so much that it would be beneficial to group individually. Initial review of the literature previously discussed in Section 2.5 explored views of both student nurses and registered nurses; whilst opposing views were evident within these groups they were not isolated to particular groups. Studies included in the literature review provided initial insight to the views of students and registered nurses from varied clinical backgrounds and on occasion data were collected from both student and graduate nurses concurrently (Moxham et al., 2013). For the purpose of analysing both literature and qualitative data for this study the groups were not separated however within the thesis any narrative clearly outlines whether the data is collected from students, registered nurses or nurse educators.

3.5.1 Research Process

The three structured phases to the research process included ten steps, which are numbered in Figure 3.1 to guide the reader through this Section.

3.5.2 Theoretical Phase

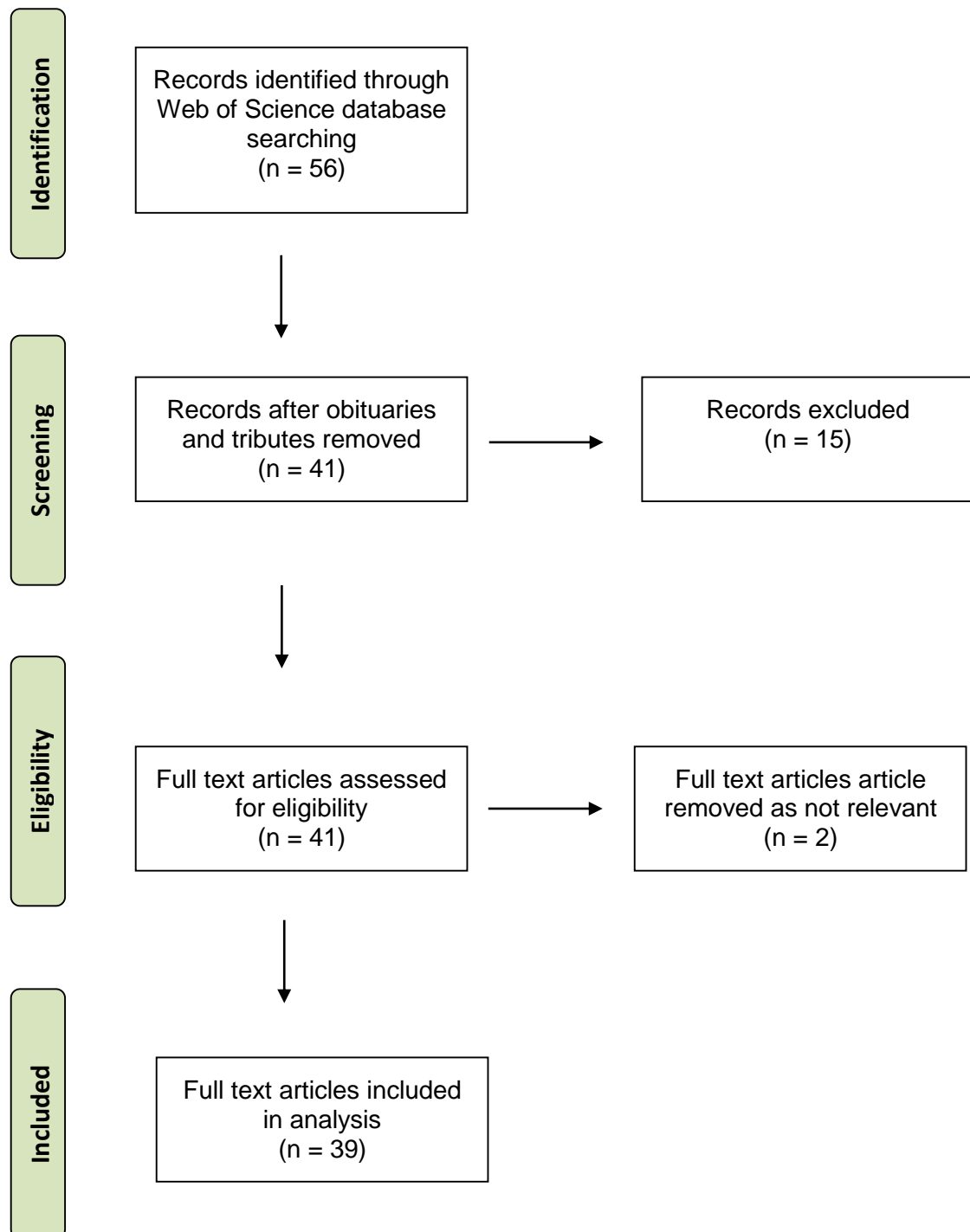
Step 2: Identifying uses of the term 'role model' within cross discipline literature

A systematic retrieval of literature was conducted to find definitions and uses of the term 'role model' across all domains to capture current use of the term. The following search strategy was conducted across an 'all databases' advanced search in the Web of Science/Knowledge (WOS). The WOS searches via Thomson Reuter's multidisciplinary databases and was considered appropriate for retrieving multi-disciplinary publications. A truncation search of "role model*" of all articles and reviews between January 2014 to January 2015. The aim of

the search was to acquire understanding of the term role model as used across the disciplines (Schwartz-Barcott and Kim, 1986).

The search resulted in the identification of 56 papers. After exclusion of personal tributes and obituaries ($n=15$) and irrelevant articles ($n=2$ one did not refer to role modelling, one related to cells rather than humans,) 39 articles were finally captured for analysis (Figure 3.2).

Figure 3.2: Flow diagram of literature captured for analysis ‘role model’



Nationality of paper, discipline, key points and definitions of the term ‘role model’ were identified and recorded. A record was also made of how many

times the term ‘role model’ appeared within the text to capture relevance of the article to role modelling. Country of origin and discipline of publications are presented in Figure 3.3 & Table 3.4.

Figure 3.3: Captured Multi-Discipline Literature

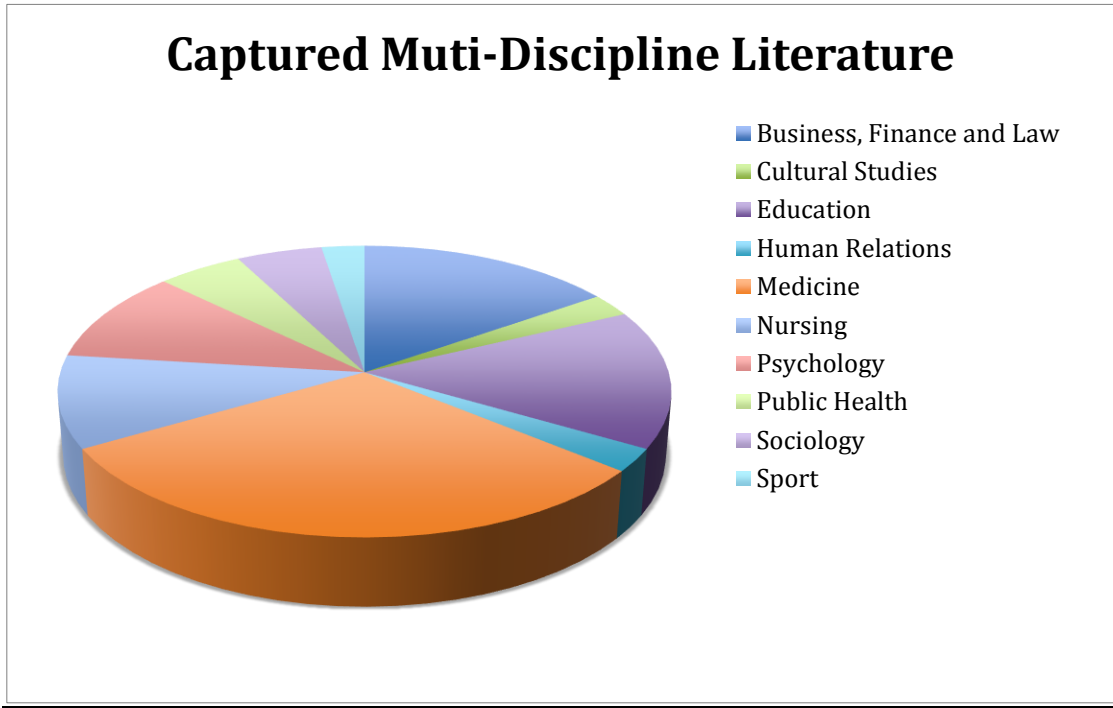


Table 3.5: Country of origin of multidisciplinary publications

Included in study after application of Inclusion/Exclusion Criteria (n=39)	
<u>Country of Origin</u>	<u>Total</u>
U.S.A.	14
U.K.	7
Germany	4
Canada	2
Israel	2
Austria, Australia, Belgium, Chile, Hungary, India, Italy.	1 each
Netherlands, Portugal. South Africa.	

Publications were read and reread; definitions of the term role model were recorded and thematic analysis conducted to search for key themes. The process was inductive in nature, without any prior assumptions surrounding implicit uses and aimed to provide a theoretical platform from which to later analyse the more specific concept of nurses as role models in health-promoting behaviour.

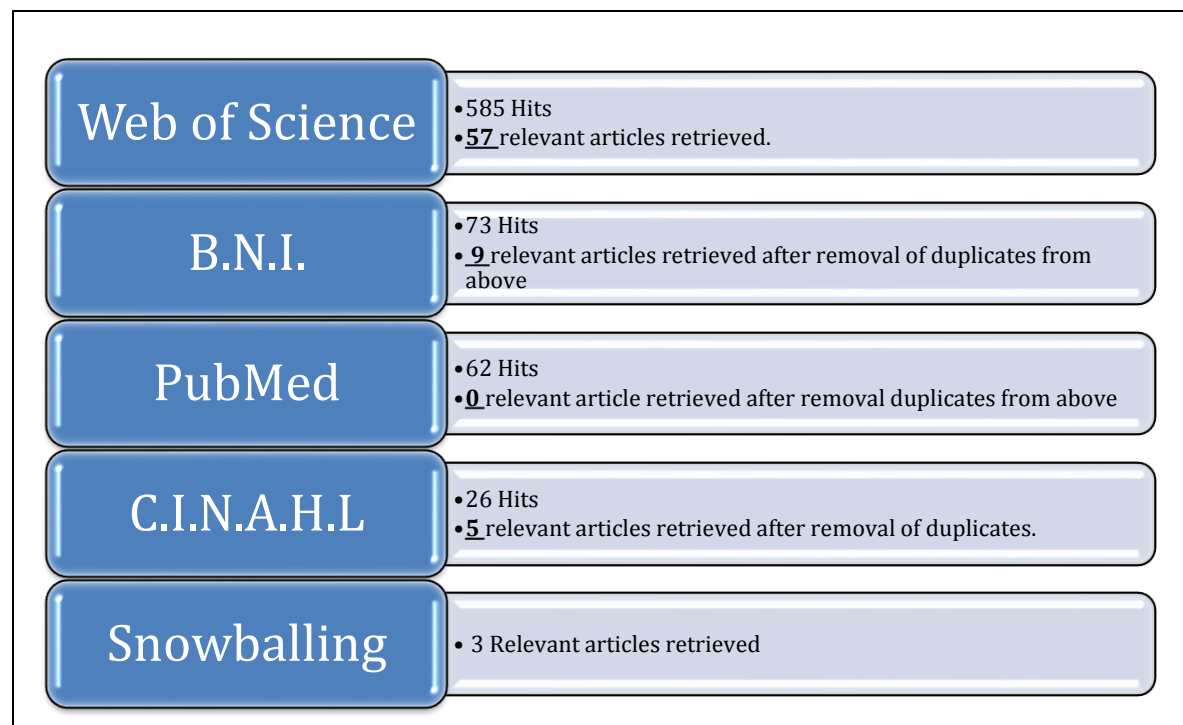
Step 3: Systematic retrieval and analysis of nursing literature

A systematic search of literature surrounding the concept of nurses as role models in health promoting behaviour was conducted as a separate step from the review of cross discipline literature on role modelling. The aim of this step was to determine and record defining attributes, antecedents and consequences in the literature of specific relevance to the field of study, rather than conduct a critical analysis, however critical consideration was given to research studies retrieved in the search. Identifying defining attributes is an iterative process as understanding of the core meaning develops. Defined attributes, antecedents and consequences were a result of reading, rereading and abstraction, not a case of picking and choosing preferable attributes but careful judgement of 'best fit' of predominant findings. Papers were highlighted electronically and comments inserted to label antecedents, attributes and consequences. When all instances of the concept are collected defining attributes may change as understanding increases (Walker and Avant, 2014), so papers were regularly reread.

Relevant databases were accessed using the search terms "role model*" AND nurs* AND health* in English Language only: Web of Science (WOS), British Nursing Index (B.N.I.), Pub Med and CINAHL. All literature published since 1986 until February 2015 was included. This date was determined because in 1986 the United Kingdom Central Council for Nursing (UKCC) publication was released: The Project 2000 Report: A new preparation for practice (UKCC 1986) which presented the UKCC's commitment to producing effective 'promoters of health' through nurse education reform at the time (Whitehead, 2002). All articles including opinion pieces and editorials were included in the search to capture nurses' opinions, attitudes and beliefs. The search extended beyond the title of publications to ensure rigour. WOS allowed a search in topic,

B.N.I AND C.I.N.A.H.L in abstract, and Pub Med in title and abstract. In total 736 hits were examined for match to nurses promoting healthy behaviour which provided 71 articles for analysis. Three further articles were identified from reference lists, resulting in 74 publications.

Figure 3.4: Captured nursing literature



As with cross discipline literature, the number of instances of the term 'role model' was noted in each source to assess the weight of focus on the concept. A table of all publications was formulated to keep a transparent record of information; citation, summary of publication and list of all attributes, antecedents and consequences referred to in the text.

3.5.3 Fieldwork Phase

The primary aims of this fieldwork phase were to i) promote theoretical clarity for the concept of role modelling in the context of the NMC requirement for student nurses to become role models in health promoting behaviour and ii) investigate student nurses, nurse educators and RNs experiences and perceptions of role modelling health-promoting behaviour. Secondary aims

were also specified: i) to explore perceptions of whether the educational experience prepares students through education to be role models in health promoting behaviour ii) to identify factors that nurses perceive to affect their ability or desire to be healthy role models. Thematic analysis of qualitative data took place, which subsequently contributed to the identification of antecedents, attributes and consequences.

Step 5: Focus groups

Focus groups were chosen for this study because they offer access to interaction and a meaning-making process to provide deeper understanding of a topic. They also offered the opportunity to appraise multiple opinions (Cyr, 2015) to subsequently be integrated with evidence from retrieved literature. Participants attitudes, priorities, language and framework of understanding can also be highlighted in thematic analysis of focus group data (Kitzinger, 1994). Prior to commencing the qualitative stage of this study a potential list of questions for focus groups was drafted and as information was gained from the theoretical phase (analysis of nursing documentation), the topic guide was further developed and adapted to reflect previous research (Appendix 1). Questions included an introductory question, a series of open ended questions and a closing question: “any other comments about the topic of role modelling to encourage health promoting behaviour?” to offer participants the opportunity to raise points that had not already been covered but which they considered important (Appendix 1). This guide offered structure to the process but when appropriate the sequencing was altered to incorporate the natural flow of discussions.

Focus groups with participants that have common characteristics is a way to better understand how they feel or think about an issue (Krueger and Casey, 2009) and Kitzinger (1994) considers homogeneous groups useful when status between participants is different. Focus groups for the present study were therefore conducted amongst participants of equal standing to facilitate open discussions (2x student nurses, 2x RNs and 2x lecturers). Decisions about how much qualitative data to collect are closely linked to the level of analysis and the most important issue is to collect sufficient data to substantiate meaningful

claims (Tracy, 2010). It was envisaged that 6-8 participants in each six focus groups would determine a sample size of 36-38 which would provide sufficient data to see nuance and complexity (Tracy, 2010). Three to six focus groups can be considered a medium sized project (Braun and Clarke 2010), which in this instance was to be combined with theoretical analysis. It was planned that this would be reviewed if recruitment was poor and subsequent groups would be arranged. No particular representation was sought within each focus group, however, a range of age, speciality and field of nursing was predicted due to the inclusion of students, registered nurses training to be mentors and educators. A relatively unstructured style to conducting focus groups was used to encourage participants to talk to each other rather than the researcher, thus offering an opportunity to understand meanings and interpretations (Morgan, 2002). Discussions between focus group members may lead to reflection and consideration of ideas which supports a social constructivist perspective that underlying opinions and attitudes may be subject to change (Holland, 2004).

Participant Pool

A university was approached for research access, which provides clinical placements for students, and postgraduate education for nurses, across a range of NHS Trusts and independent organisations in London and South East England. Thus access provided recruitment from a wide range of clinical areas. Whilst the researcher of the present study was working in a Higher Education Institution and had access to students, registered nurses and nurse educators, it was considered important to access a participant pool at a different university to ensure that participants were unknown to the researcher, and therefore avoid being influenced by a previous working relationship with the researcher. To meet the research aims identified in this Section, purposive sampling offered an opportunity to provide in depth understanding and insight into the views of nurse educators and third year students. Third year students would be approaching completion of their education to prepare them to meet the statutory requirements for registration outlined in the NMC's (2010) standards for pre-registration nurse education, which was the rationale for recruitment. Furthermore, they would have gained clinical experience and contact with RNs, to reflect upon when participating in focus groups. To understand if education

is perceived to prepare students to be healthy role models the views of nurse educators were also sought, as they would have insight into the educational process. Convenience sampling of registered nurses took place by approaching a group attending a mentorship course at the university to prepare them for teaching and assessing student nurses in clinical areas. This provided a sample from a range of clinical backgrounds and therefore provided data from 'real-life' conversations within the group (Kitzinger, 1994).

3.5.3.1 Preparing for and conducting the focus groups

Recruitment

Access was via a gatekeeper, a senior university academic. A recruitment email was sent to academic staff and students with a flyer, which provided an overview of the study and the researchers email address. Incentives included entry to a £100 voucher draw plus lunch and refreshments. The initial response from students was low and I was therefore provided access to speak to students directly at the end of a scheduled lecture. The opportunity to explain to students that volunteering would provide first-hand experience of engaging in research which would contribute to their profile when applying for staff nurse posts, provided the motivation for participation.

Academics made direct contact with the researcher and a doodle poll was used to identify convenient times. The lead academic responsible for mentor training requested volunteers and arranged suitable times. Volunteers were emailed two weeks in advance of the focus groups with participant information sheets (Appendix 2), to provide them with time prior to participating to read and reflect on the information and decide whether to participate.

Procedure

Prior to each focus group a classroom within their usual environment was prepared for participants' arrival by arranging the room to include circle seating and making refreshments accessible. It was considered important that participants should feel comfortable in a quiet, familiar environment. To minimise background noise and distraction, a sign was posted on the door requesting that passers-by were quiet and did not enter the room. Participants were welcomed in an informal manner (Morgan, 2002), creating a relaxed

atmosphere to encourage people to talk. Participants were firstly asked if they had read the participant information sheet and for those who had not, five minutes was provided for them to read this through. Consent forms (Appendix 3) were completed and collected by the researcher and participants were also asked to complete a participant demographic form (Appendix 4) to allow review of any relationship between results and the sample (Braun and Clarke, 2013). At this stage in the process participants were reassured that their anonymity would be protected; the organisation in which they worked would not be made aware of their participation and any future publications would ensure that their words were not traceable to them as individuals. Guidelines were introduced such as checking phones were switched off, outlining aims of the session and reassurance that there were no right or wrong answers.

The topic guide was used throughout as a prompt to provide some structure to the discussions and to address the research questions. Having a well thought through topic guide enabled me to focus on what was being said and develop a rapport with participants. Non-verbal and gentle verbal communication cues were used to encourage all participants to contribute (Richards, 2015). Prompting and probing encouraged participants to expand on statements they made and often involved such subtleties as “mm” or “oh yes?” Using expectant silences were also useful in indicating that further information would be useful and often resulted in valuable further comments being provided. Each group was conducted in approximately one hour and notes were made of style of speaking tone; for example, ‘with humour’ when a participant was making a light, sarcastic or flippant comment. As there was usually a week or two between each focus group, I had an opportunity for valuable reflection and learning on discussions which also resulted in a small addition to the topic guide question which is discussed in Section 3.5.4.1.

Audio recordings were uploaded to a password secure laptop within a day of being obtained and transcribed verbatim by the researcher. Infrequent informal notes were taken throughout the discussions as an aide-mémoire for a reflective journal, written immediately after each session. Keeping a journal

helped create transparency and critical self-reflection on research design throughout the research process (Ortlipp, 2008).

3.5.4 Qualitative data analysis

Interviews

It was acknowledged that individual focus groups of registered nurses, students and educators may provide a variance in experience and opinions. However, to meet the broad aim of the study, which was to investigate student nurses, nurse educators and registered nurses' experiences and perceptions of role modelling health-promoting behaviour, qualitative data were analysed together. However, within this thesis any narrative clearly identified whether the data were collected from students, registered nurses or nurse educators.

Spoken words and significant points in notes, such as laughter or pointing to another member were included in transcripts. Certain body language was captured on tape, for example "so everyone is nodding their heads does that mean that you are in agreement?" Member checking was not planned following each focus group as recruitment was not easy and it was envisaged that minimum response and engagement for follow up would be obtained. It is argued to be useful to check that explanations make sense to participants by member checking, however planned feedback from participants should be considered as more data which can be problematic; the consultation process takes time and can be complicated (Richards 2015). Therefore, for the purpose of the present study, every opportunity was taken during focus groups for respondent validation through clarification of meaning of ambiguous statements. For example, "you have made an interesting point, can you expand on that?"

Transcribing recordings promptly between groups myself facilitated immersion in the data and provided a valuable opportunity to reflect on data between each focus group. The time for transcribing was included but not limited to the time between focus groups and transcribing continued beyond the data collection period. To ensure the quality of transcription, indications of 'what' was said was

supported by 'who' was saying it, which involved multiple replaying of recordings and note making of individual voices (P1, P2) to ensure that repetition by one individual did not appear as agreement by another. Limited punctuation was used to reduce sentence errors and reconstructions which might change meaning. Pauses and overlapping speech were also indicated. When transcripts were completed a final stage of listening to the recording while reading the text was conducted to check and amend interpretation.

Thematic analysis (TA) was used to identify and analyse patterns in the data through familiarisation, coding, searching for themes, reviewing themes, defining and naming themes and writing up (Clarke and Braun, 2013).

Reading, familiarisation and noting items of interest in data took place before initial coding. Coding can be seen as generating the bones of analysis and theoretical integration assembles the bones into a working skeleton (Charmaz, 2006). It involves not just labelling of data but is cyclical, linking data to ideas and ideas to data (Saldana, 2013). Line-by-line initial manual coding took place, using an approach which incorporated In Vivo and process coding. In Vivo coding uses short phrases or words from participants' actual words keeping the researcher as close to the original meaning as possible. Process coding identifies gerunds or "ing" words as codes. For example: *being honest, caring, being open*. Initial codes were revisited and subsequently categorised for thematic or conceptual similarity in a focused approach (Saldana, 2013). Microsoft Word search function supported manual coding, searching for words and phrases. A coding bank was developed: a compilation of codes, descriptions, and examples for reference. Reviewing and revising of codes, cross-referencing with the coding bank, resulted in 395 codes and ensured my confidence that codes were a fair reflection of discussion.

Broad patterns or themes were searched for amongst codes resulting in provisional theme identification. Provisional themes are referred to as candidate themes (Braun and Clarke, 2013). Candidate themes were identified, reviewed and revisited, regularly returning to the dataset. This ensured codes accurately reflected original meaning and fitted within themes appropriately. Candidate themes were identified manually with a visual map using a large pin

board, which allowed grouping and regrouping of codes. Some codes that were deemed large or complex enough to be supported by other codes were 'promoted' to a theme. A thematic map was developed to outline the themes and subthemes. Preliminary narrative written around each theme, interpreting codes and selecting quotes to support the narrative facilitated reflection on themes, resulting in collapsing some candidate themes together and splitting other large themes.

3.5.4.1 Trustworthiness of qualitative research

The researcher

The qualitative stage of this study involved interpreting data, which introduces a risk of researcher bias. The researcher themselves is an instrument for collecting data; "you as a research instrument bring a particular lens or filter to your data collection process" (Yin 2011: 270). The origin of my interest for this study evolved from a career in nursing and nurse education. Personal observations of unhealthy behaviours of student nurses and knowledge of a rising demand for student emotional support introduced subjectivity surrounding my beliefs of the health of nurses. Throughout a process of peer review and supervision I became aware from the outset that I should be honest and transparent of my bias surrounding the health of nurses and my motivation to make improvements through education which I addressed by being introspective and authentic from the outset (Tracey, 2010). Carefully considering the research aims and objectives, I considered it important to obtain experiences beyond those in similar roles to myself and seek the perspective of RNs, student nurses. I also considered conducting focus groups in an environment where I worked might influence the openness of participants, therefore access was gained to an institution without prior knowledge of my research interest.

An audit trail of data analysis was maintained in regular discussions with my academic and professional supervisors to ensure credible and truthful interpretations (Scwandt et al., 2007) and minimise researcher bias. The audit trail was maintained by presenting revised versions of codes, themes and thematic map supported with narrative which contributed to the dependability

of the findings thus increasing the credibility of the research findings (Lincoln and Guba, 1985). A reflective journal completed immediately after each focus group allowed for critical self-reflection. For example, I became aware of my pre-existing assumption that participants would be aware of the NMC pre-registration requirement for student nurses to be role models in health promoting behaviour. Following the first focus group, participants revealed they were not previously aware of the NMC requirement to be healthy role models, subsequent groups were therefore asked if they were aware of the requirement; the vast majority were not. Another pre-existing assumption was that participants would be able to consider what being role models in health promoting behaviour meant to them, however most struggled. Thus a minor topic guide change included an opening question: “what do you think that means?” which appeared to focus participants’ thoughts from the outset. Ethical approval was not obtained for this minor change as it added clarity to existing questions rather than being an addition to questioning. Keeping such a research trail contributes to the transparency of the process (Ortlipp, 2008).

Throughout the time the present study was being conducted Simon Stevens (NHS Chief Executive) argued “when it comes to supporting the health of our own workforce, frankly the NHS needs to put its own house in order” (NHS, 2015); thus increasing, political interest and pressure for nurses to be healthy role models. It was important throughout the research process to consider and be aware of my own stance on the subject and presenting at national conferences, holding question and answer sessions following presentations helped. Prior to the fieldwork my motivation was to improve the health of nurses because of my perception of the wider impact on patients through role modelling. However, throughout the process I became aware of a shift in my stance surrounding the subject due to gaining insight and greater understanding of the complexities surrounding nurses being healthy role models which will be further discussed in Chapter 7.

Representation

Selection of quotes and accurate representation during the writing up stage required careful consideration to ensure validity of findings. Qualitative analysis

involves “interpretation, which is informed by particular subjective and theoretical (and political) lenses” (Braun and Clarke 2013, pp 64). Identification of key themes and selection of participant quotes to represent themes and sub themes involved revisiting the data to ensure genuineness and accuracy of choice. This required reading and rereading of transcripts and asking myself: “is this exactly what they mean?” “am I seeing this through the participants’ lens or mine?” At no point should quotes be ‘cherry picked’; they should be representative of the data being analysed and chosen with careful consideration of the researchers’ political stance to avoid any researcher bias.

3.5.5 Final Analytical Phase

The final analytical phase involved weighing, working and writing up findings and considering: i) the relevance of the concept, ii) if the selection of the concept seems justified, and iii) to what extent the theoretical and empirical analysis support the presence and frequency of the concept within the population under study (Schwartz-Barcott and Kim, 2000). In practise this involved integrating findings from fieldwork and theoretical phases. Qualitative data was re-examined and defining attributes, antecedents and consequences identified (step 7) which were subsequently compared to those, previously identified in literature. Thus, the qualitative data was used to corroborate and refine the concept analysis based on literature and integrated with tables produced in the theoretical phase. A final concept analysis table was therefore formulated. Throughout analysis of literature and qualitative data a note was made of model, borderline, related and contrary cases. Notes were considered and papers and qualitative data revisited to search for cases (step 8) and empirical referents (step 9) which provided deep reflection and was helpful in defining the concept (Schwartz-Barcott and Kim, 2000). Tables demonstrating findings and sources of integrated antecedents, attributes, consequences, cases and empirical referents are provided in Chapter 6.

3.6 Ethical Considerations

This study was carried out with full approval from the Research Ethics Approval Committee for Health (REACH) at University of Bath (Appendix 5) and conducted within the guidelines of The Research Governance Framework for Health and Social Care (DH, 2005). Approval was also gained from the Faculty Research Ethics Committee (FREC) at St Georges and Kingston University London who approved the schedule for recruitment, consent and procedures. NHS Research and Development approval was not required locally as all participants were recruited and interviewed while at university. All data storage adhered to Data Protection Act 1988 and 2003 amendments regarding collection, processing, keeping and disclosure of personal data. Personal data was stored on a password protected secure computer. Consent forms were locked in a cupboard at the researchers' home. Participant Information Sheets and consent forms were designed to clearly inform participants what agreement to volunteer involved, what would happen to them and their data, and of the right to leave the focus group at any time. This included an explanation that all information provided by participants would remain anonymous and confidential. All participants were requested to refrain from discussing other participants' contributions outside of the group or with other people. The Participant Information Sheet also confirmed that the transcript would be anonymised and that any extracts from the transcript included within the findings section of this thesis or in future publications would protect individuals from being identifiable. The gatekeeper, head of pre-registration nursing on site was not made aware of participants' details, so potential volunteers would not feel discriminated against if they chose not to take part. Incentives for research participants raise some ethical questions; it is important that incentives do not affect the free giving of information or influence the diversity of participants: an Amazon voucher prize draw was chosen as it would be of equal interest to all participants. Following the final focus group, the draw took place by an uninvolved individual blindly selecting a participant consent form. The winner was contacted, the prize accepted and sent via email.

Ethical issues surrounding data collection through focus groups include

anticipating and preventing potential harm to participants. It was possible when discussing sensitive issues about personal lifestyles some participants could feel uncomfortable so careful consideration was given to the topic guide to minimise risk. Previous experience as a RN and personal tutor provided me with confidence and sufficient experience to conduct the groups sensitively however, if necessary the participants would have been sign posted to general practitioner, personal tutor or line manager. If individuals monopolised conversation, non-verbal cues were given to encourage more diffident participants to engage. Participants were made aware that the study was part of a doctorate and an opportunity was made after each session for individuals to ask questions about the aims of the study itself.

Consideration was given to issues beyond data collection to ensure findings were accurately reported. Regular supervision throughout the research process ensured awareness of any assumptions of the researcher. Frequent replaying of recordings took place to ensure familiarity of data. A clear and transparent documentation trail was maintained and conversations with supervisors challenged potential assumptions. Supervisors encouraged critical assessment of data by conducting independent audits of data coding which contributed to the quality control process.

3.7 Summary

This chapter explained the rationale behind the adapted three-phase hybrid approach to concept analysis and development to answer the research questions for the present study. Each stage of the research process has been described and findings will be outlined in the following chapters.

Chapter 4: Findings Theoretical Phase

4.1 Introduction

This chapter presents findings from the theoretical phase of the study. The aims of the theoretical phase were to examine literature to identify:

- Current definitions of the term 'role model'
- Implicit and explicit uses of the term 'role model'
- Attributes, antecedents & consequences of the concept of nurses as role models pertinent to health promoting behaviour

Meeting such aims contributes to the rigour in developing clarity of meaning to a concept (Walker and & Avant, 1983, Schwartz-Barcott and Kim, 1986). Findings presented in this chapter are the result of two distinct literature searches identified as steps 2 and 3 in the methodological framework outlined in Chapter 3 (Section 3.4). The first search accessed multi-disciplinary literature to identify uses of the term 'role model' within academic literature and findings, which identified current definitions and implicit uses of the term 'role model', are presented. Findings from the second search of nursing literature (step 3), which identified explicit uses of the concept, 'nurses as role models of health promoting behaviour' are then presented. Defining attributes, antecedents, consequences and a related case of the concept, identified from the literature, are finally presented.

4.2 Determining implicit meaning of the concept: identifying uses of the term 'role model' (Step 2)

The aim of this stage of the process was to determine implicit meaning of the concept: nurses as role models in health promoting behaviour by identifying uses of the term 'role model'. Using the search strategy and process outlined in Chapter three (Section 3.4) a systematic retrieval and analysis of academic literature was conducted across all disciplines and subjects. Thirty-nine papers from across ten disciplines and specialities were analysed. Definitions retrieved

from the literature and referred to in the text of this chapter are collated in Table 4.1.

Table 4.1: Definitions of role model identified in multi discipline literature

Definition	Source	Discipline	Original development
An individual perceived as exemplary or worthy of imitation	(Mutter and Pawlowski, 2014)	Medicine	Work of Yancey et al (2011) which cites Bandura's learning theory to support this definition
Cognitive construction based on the attributes of people in social roles an individual perceives to be similar to him or herself to some extent and desires to increase perceived similarity by emulating those attributes	(Durbin and Tomlinson, 2014)	Business	Original work of Gibson (2004) which draws on career theory, social comparison and self-concept theories.
A person who is respected, followed, and copied	(Gladding and Villalba, 2014)	Psychology	Cites an earlier mixed methods educational study as basis for definition (Bricheno, 2007) which is positioned within Bandura's learning theory
An individual who provides a code of behaviour and a set of values to be emulated	(Madhavan and Crowell, 2014)	Sociology	
Individuals admired for their ways of being and acting as	(Côté and Laughrea, 2014)	Medicine	Draws on previous qualitative research of Côté (2000)

professionals			
The observation of behaviours or attitudes of someone that one admires and the subsequent adopting of those behaviours or attitudes for oneself	(Baldwin et al., 2014)	Nursing	Draws on a medical scholarly article (Creuss, 2008) to state what role modelling is widely accepted to mean

Multi discipline publications, which presented definitions (Table 4.1) made reference to Bandura's theory as a framework to role modelling (Mutter and Pawlowski, 2014, Gladding and Villalba, 2014). Reference to the relevance of Bandura's work discussed in Chapter 2 (Section 2.2.2) included behaviour being learned through factors, which include observing others and self-efficacy beliefs influencing how people think, feel, motivate themselves and behave. Durbin and Thompson (2014) do not cite Bandura, however principles of social cognitive theory of identification can be recognised within the definition; when the individual identifies with or feels they have more in common with the model, the more likely they are to mimic behaviour.

Reading and rereading of multi discipline literature provided insight to inform what role modelling is: the matter of being a role model. Regular reference was made to positive and negative role models. It was identified in the literature that to be a role model you need to be motivational, transmit ethics, and demonstrate professional skills and conduct. Gender, similarity and parental influence were identified as relevant to determining the impact of role models' determining factors. Insights from the multi discipline literature are now presented.

4.2.1 The matter of being a role model

Being motivational was an attribute of being a role model identified in multi discipline literature. Mutter and Pawlowski (2014) examined whether success of professional athletes impacts on amateur sport participation, analysing the motivational effect of male and female members of German football teams. Past

success of national teams was found to have slight increase on amateurs participating in the sport. However, success appeared to only influence those already engaged in the sport. The authors argue that two effects of sporting role models are distinguishable: being motivational which encourages frequency of sport and being inspirational which affects starting a sporting activity. This suggests that being motivational only has an impact on those already engaged in an activity. The authors constructed a theoretical framework of sporting role models, tested with a stated preference valuation. Relevance, availability and similarity of role models were identified as main predictors of being a motivational role model (Mutter and Pawlowski, 2014). Role models are “anchors of motivation” which embody ideals and values (Yair et al., 2014).

The terms role model and hero were used interchangeably in one German educational study, which explored the influence of the Holocaust on Israeli and German students’ perceptions. Yair et al. (2014) considered historical role models or heroes as used in educational systems to socialise and deliver moral messages; as educational vehicles to motivate students and provide inspiration.

The motivational aspect of role models was referenced in the public health domain (Cheskin et al., 2014). A small mixed methods US public health study evaluated a fire service initiative of developing role models to motivate colleagues to change their health behaviours. The authors claimed that lifestyle changes could be made and three participants in leadership roles, were targeted for health improvement to become role models for health. However claims for healthy role models in the fire service were tenuous based on this study of three participants; one withdrew shortly after recruitment because he could not adhere to the recommended diet.

Role models can *transmit ethics* providing an ethical template that Madhavan and Cromwell (2014) argue is a function of a role model. The authors conducted a sociological study using a grounded theory approach to examine how black youths in South Africa construct role models (Madhavan and Crowell, 2014). Participants identified people as ethical templates by moral responsibilities, career responsibilities and fulfillment of education. However, findings were

specific to the cultural context of lives of youths in rural South Africa. Alignment of a role model was considered reflecting a strategy for youths to balance individual and group identity development. Authors provided the following definition:

“an individual who provides a code of behavior and a set of values to be emulated” (Madhavan and Cromwell, 2014: 717)

Role models transmit ethics through appropriate workplace behaviours (Brown and Trevino, 2014). Brown and Trevino (2014) investigated role modelling as an antecedent to ethical leadership and reported three types of ethical role models: childhood role models, career mentors, and managers. The field study, conducted at a large US insurance company, surveyed employees and managers, found childhood role models had most impact on younger leaders and career mentoring on older leaders (Brown and Trevino, 2014). Reference was also made to social learning theory (Bandura, 1977) which has been discussed in Chapter 2 (Section 2.2.2). Ethical leadership and ethical role modelling are however different constructs; ethical leaders are individuals with formal authority whereas ethical role models function within any position inside or outside a working environment (Ogunfowora, 2014). The author of a Canadian qualitative study (Ogunfowora, 2014) across five not for profit organisations, reported a relationship between ethical leadership, organisational behaviours and job satisfaction within a business environment. The author argued the importance of investigating leaders' role modelling perceptions to further understand the impact of ethical leadership on employee behaviours and attitudes. Participants reported to rely on non-supervisory role models when coping with ethical issues, which raised the question of status of role models; a weakness of the paper was the lack of exploration of who these role models were.

Demonstration of professional skills and conduct is required of role models (Côté and Laughrea, 2014, Benbassat, 2014, Branch Jr et al., 2014, Baldwin et al., 2014). Medical publications mostly considered role modelling as learning professional skills and conduct from peers and senior members of the

profession. Côté and Laughrea (2014) interviewed forty preceptors who described role modelling as part of the medical competency framework and identified three main attributes of role models: clinical competence, teaching skills and personal qualities of compassion, enthusiasm and honesty. Role models are:

“individuals admired for their ways of being and acting as professionals.” (Côté and Laughrea, 2014: 934)

Benbassat (2014) argued that medical students should be encouraged to discern those worthy of imitation, reflecting on preceptors' behaviours, thus encouraging a critical and selective adoption of role models' behaviours rather than blind imitation. This implies that students have an understanding of what constitutes a good role model. Benbassat (2014) argued that openness in sharing doubts and transparency in deliberations is the main attribute of clinical role models. Using case reports Milder et al. (2014) presented an example of poor professional and personal role modelling to medical students. The author reported that being a professional medical role model included demonstrating skills such as teaching and conducting ward rounds, good doctor patient relationships and integrating psychosocial dimensions of medicine (Milder et al., 2014).

Professional attitudes or civilised codes of behaviour of medical educators as role models influences post graduate speciality choices (Stahn and Harendza, 2014). Stahn and Harendza (2014) conducted fourteen in depth interviews with German medical educators and found code of behaviour and clinical expertise in speciality the most imitable characteristics of role models. The authors recommend increased awareness in medical academics to recognise they are seen as role models who influence students' choice of specialities. It should be noted that the results of this study were from one university, which influences the generalisability of findings. Branch Jr. et al (2014) also highlighted the influence of medical teachers as role models in a quantitative cohort study. The authors examined students' ratings of clinical teachers comparing learners in a multi institutional faculty programme compared to contemporaneous controls. Although this study focused on humanistic clinical competencies the paper highlights the impact of positive teaching role models on the learning

environment (Branch Jr et al., 2014).

Nursing literature provided three sources for consideration for the generic meaning of role modelling which focused on professional factors. A systematic literature review of nursing literature reviewed 33 studies addressing role modelling in undergraduate education (Baldwin et al., 2014). The authors considered there to be many interpretations of role modelling and drew on a scholarly article from medical literature (Cruess, 2008) to provide a definition of what they considered as widely accepted understanding:

“the observation of behaviours or attitudes of someone that one admires and the subsequent adopting of those behaviors or attitudes for oneself” (Baldwin et al., 2014: 18)

Baldwin et al. (2014) reported imbalance between recognising role modelling behaviours in clinical and academic settings; clinicians as influential role models for practice were well recognised in the literature however despite nurse academics having significant contact with students, little recognition was evident. Baldwin et al. (2014) argued that the nurse academics role surpasses providing knowledge and includes being a role model in professional behaviour. A small column (Coghill, 2014) in the nursing press argued for nurses as role models for tolerance and inclusivity suggesting it a duty to lead by example. Such suggestions make assumptions surrounding the power of the profession. The final article in the same journal calls for nurses to be role models by being courageous and standing up for patients by reporting care failings (Lockett, 2014).

Professional and personal boundaries were the focus of a German psychology study (Koch and Binnewies, 2015) which examined the importance of supervisors as role models in the context of work-home life boundaries. Results demonstrated segmentation behaviour of separating work and home by supervisors was perceived as work-life-friendly role modelling. Koch and Binnewies (2015) discussed boundary management theory and considered blurring of professional and personal boundaries as complicated. Individuals create and maintain boundaries between life and work domains (Bulger, 2007). This is relevant to the requirement for nurses to be role models in health

promoting behaviour, and the argument from the International Nursing Council that the world's nurses make a personal commitment to improve their health and wellbeing, acting as role models to families, friends, workplaces and local communities (ICN, 2010).

The three articles that focused on role modelling within a health professional environment did not provide any insight into what role models do or what might impact on effectiveness. The first, a letter to an editor, called for investment in education for Indian women with diabetes (Gupta and Kalra, 2014). The other two papers were retrieved from public health journals. One (Friedman et al., 2014) explored the potential of a health provider role modelling health behaviours for diabetic patients with community partnership relationships. The other paper (Ravara et al., 2014), a quantitative study, examined smoking behaviours of Portuguese physicians. The results demonstrated smoking behaviours of physicians were similar to the general public, which the authors argued did not correlate with their expected status as role models. This paper did not consider what was understood by role modelling other than the expectation to not smoke.

4.2.2 Determining factors of a role model

Gender relevant role models were explored within the literature (Bamberger, 2014, Johnson, 2014, Brownhill, 2014, Balint et al., 2014, Gladding and Villalba, 2014, Jagsi et al., 2014). The educational sector's interest in gender specific role models was particularly evident. Brownhill (2014) explored perceived male role models working as teachers with 0-8 year olds in a mixed methods approach. The authors suggested lack of clarity surrounding qualities of a male role model exists within education due to a tension between qualities that are a result of individual beliefs and those anticipated or enforced by others. This implication is relevant to nurses, who may consider the requirement to be healthy role models enforced by others.

In a mixed methods study conducted in Israel (Bamberger, 2014), a programme designed to include contact with female scientist role models was evaluated for

inspiring girls to choose science, technology, engineering, and mathematics (STEM) courses. The author reported that students felt respect for female scientists and were sure of their cognitive ability, but they did not increase students' interest in commencing STEM subjects. The implications of this are that role models chosen by others are not necessarily helpful, suggesting that individuals choose their own role models to affect personal choices. Findings were culturally specific to participants in a Jewish modern orthodox school, which affects generalisability of the study. Jagsi et al. (2014) explored gender in role modelling across the US, over two years, searching for significant associations between 48, 235 graduates and: sex of lecturer, sex of university chair and female medical students' choice to pursue a medical speciality. Findings did not reveal significant association between female role model exposure and choice of speciality (Jagsi et al., 2014). However, the authors reported a link between female students attracted to programmes and higher numbers of female residents (junior doctors under supervision), which supports the previous argument by Baldwin et al. (2014) that clinical role models have an influential role.

Female instructor role models boost self-efficacy and academic achievement of female students (Johnson, 2014). The impact of gender specific instructors on student achievement was explored in one US University by a quantitative study (Johnson, 2014). Female instructors had a positive impact on female students but not a statistically significant effect on male students. This study had several limitations due to confounding variables in findings such as composition of class, gender and discipline of course. Paredes (2014) examined impact of same gender teachers on achievement in eighth grade students in Chile and found female teachers had a positive impact on girls without a negative effect on boys. The dummy variable in the methodology tested out a role model hypothesis, considered mothers' education and teacher bias which supports the authors argument that impact was caused by a role model rather than teaching effect (Paredes, 2014). Paredes (2014) considered identification part of role modelling; therefore, same sex role models should be most influential. The implications of this are relevant when the nursing profession is 90% female (Vere-Jones, 2008). Women in a male dominated

industry were found to disassociate themselves with being role models through what they do at work (Shortland, 2014). A study conducted within the UK gas and oil industry made a link between type of assignment undertaken by women and being role models: participants did not see themselves as such. This further highlights the point about individuals perceiving themselves as role models in a gender dominated industry. Attributes of a role model identified by Shortland (2014) include: 'being a trailblazer', being inspirational, supportive, encouraging and a source of information.

Balint et al. (2014) explored the influence of gender of role models presented in videos on student mentalisation, defined as understanding the mental state underlying overt behaviour, either of oneself or others (Fonagy, 2002). Psychologists designed the videos, and role modelling was demonstrated through negative and positive patient centered communication. For example, empathy was measured by recording explicit verbalisation of mental state (e.g. feeling, emotion, desire). Patient centeredness and gender were reported to have significant impact on role modelling and health care professionals were argued to be highly affected by negative role models (Balint et al., 2014). The implications of negative role models are further considered in this section. Gladding and Villalba (2014) presented a case history to explore how role models influenced a boy's life cycle through to adulthood providing the following definition as a point of reference:

“a person who is respected, followed, and copied”

(Gladding and Villalba, 2014: 114)

Boys model the men in their life and those they are exposed to in the media, therefore counsellors could help young men develop into well-grounded men by exposing them to positive role models in films (Gladding and Villalba, 2014). The authors also highlighted that people change who they wish to emulate over time or with changing circumstance which has relevance to nurses as healthy role models; many people with whom they have contact are at a point of changing circumstance in life.

Similarity was considered relevant to role modelling (Mutter and Pawlowski, 2014, Durbin and Tomlinson, 2014, Johnson, 2014, Paredes, 2014) and Greenstock et al. (2014) support this argument. Exploring health professionals as clinical role models Greenstock et al. (2014) found that despite other health professionals being more available, medical students mostly focus on medical staff to learn from. The size of the study, fifteen Australian medical students took part in focus groups, decreased generalisability of findings (Greenstock et al., 2014). Thornton and Tajima (2014) examined newspaper coverage of black-Japanese affairs and considered individuals look beyond similarity in role models. The authors reported that when looking for role models, people look for “someone or something to emulate, going beyond mere similarity” (Thornton and Tajima 2014: 146). The implications of this statement to this thesis are minimal due to the focus on cultural complexities of a minority race. Thornton and Tajimi (2014) argued role models can exist without an actual relationship; media reporting rather than on physical interactions. This has implications for nurses as role models by the way that they are presented in the media.

Parental input as role models is linked to patterns of behaviours (Vanassche et al., 2014, Draxten et al., 2014, Natale et al., 2014). Vanassche et al. (2014) surveyed 1688 adolescents across ten different US secondary schools to examine family type, adolescent externalising behaviour, child-parent relationships and role model factors. The authors reported parental role models, particularly same sex parent, were extremely important in association with drinking behaviour. The link between parental role models and patterns of behaviour has implications for student nurses becoming role models because they enter the profession with pre-learned behaviours. Draxten et al. (2014) examined impact of parental role modelling of fruit and vegetable consumption on child eating patterns: a strong Impact of parental role modelling on behaviour was reported. The authors did not consider any theoretical background or understanding of role modelling (Draxten et al., 2014). Child nutrition and lifestyle role modelling was the focus of a US study (Natale et al., 2014). Twenty-eight childcare centres, offering support to low-income families, were randomised to three intervention arms: menu modification, healthy lifestyle curriculum and teacher and parent focused role modelling curriculum. Teachers

were found to not have a strong effect as role models in this study; however, results demonstrated parental nutritional and physical role modelling significantly influenced pre-school child behaviours.

Parental role modelling has more impact on girls than boys when parents role model charitable (pro-social) giving and volunteering (Ottoni-Wilhelm et al., 2014). Parental giving and discussions about giving were shown to have significant impact on adolescents in a mixed methods USA study, which focused predominantly on qualities of parental models, identified as warmth and supportiveness. Ottoni-Wilhelm et al. (2014) made reference to social learning theory as relevant to parental role modelling. Pro social behaviour is altruistic and cannot be compared to professional role modelling however it can be argued that the role of the nursing workforce is altruistic (Cope et al., 2016).

Positive and negative role models

Reference to the concept of a negative role model is made within: medical literature (Benbassat, 2014, Guralnick, 2014, Martinez et al., 2014, Stahn and Harendza, 2014), business (Baden, 2014, Brown and Trevino, 2014, Durbin and Tomlinson, 2014) and education (Paredes, 2014). Baden et al. (2014) compared the effect of positive and negative role models on ($n=96$) business students (Baden, 2014). Students found positive role models inspirational, and wanted to follow them in future business careers. Students reported cynicism towards negative role models, producing intentions for students not to make similar mistakes. Participants considered a media bias towards negative role models rather than positive ones. Baden (2014) argued that positive role models are needed to counter negative impressions.

Martinez et al. (2014) measured medical trainees' exposure to, and impact of negative and positive role models, from the perspective of reporting drug errors. Results from this US study demonstrated a link to the likelihood of non-disclosure of harmful errors (Martinez et al., 2014). The authors considered negative role models more influential than positive from a professional development perspective, which they claim "mirrors the general psychological finding that negative events have a greater impact on individuals than positive

events” (Martinez et al., 2014: 486). The authors did not consider the relevance of cognitive dissonance to negative role models; it could be questioned whether negative role models truly have an impact on behaviour or whether people seek negative role models to justify personal choice of actions. A US article provided background and meaning to a medical competency to provide appropriate role modelling (Guralnick, 2014), discussing the work of Merton (1957). Guralnick (2014) focused on professional role modelling as a teaching strategy and argued that positive and negative role models are essential in medical education.

Durbin and Tomlinson (2014) conducted 27 interviews with successful UK businesswomen comparing career trajectories before and after part time work due to childbirth. Once part time, managers did not progress so well; argued to be partly due to lack of positive female role models in the work environment. Negative role models were perceived to not champion part time work (Durbin and Tomlinson, 2014). Durbin and Tomlinson (2014) cited Gibson’s (2004) research on career success, which suggested role models can be multiple rather than one exemplary person. Gibson (2004) proposed the following definition depicting role models as cognitive constructions based on wants, needs and ambitions of the individual:

“cognitive construction based on the attributes of people in social roles an individual perceives to be similar to him or herself to some extent and desires to increase perceived similarity by emulating those attributes” (Gibson., 2004: 136)

Gibson (2004) also acknowledged the concept of the negative role model in his original work.

4.2.3 Relevant theoretical frameworks

Multi discipline literature demonstrated that the concept of role models is founded on different theories. Predominantly, within the cross discipline literature, Bandura’s (1977) social learning theory was considered a relevant foundation to role modelling which is further discussed in Chapter Two. Further theoretical frameworks highlighted as relevant within the multi discipline

literature included social comparison theory (Festinger, 1954) and social identity theory (Tajfel and Turner, 1985).

Social comparison theory is traced to work by a social psychologist in the 1950s (Festinger, 1954) and was considered relevant to role modelling by Mutter and Pawlowski (2014). People make many judgements about themselves by comparing themselves to others, using them as a benchmark. The theory suggests that individuals are motivated to compare themselves to others they perceive as similar. This comparison is driven by the desire to assess personal abilities and attitudes (Gibson, 2004). Upward and downward social comparisons are possible to aid self-enhancement and self-evaluation. A highly motivated individual tends to make upward comparisons; a demotivated person makes a downward comparison, to make them feel better. Festinger's (1954) theory can be challenged by those who believe individuals seek out dissimilar others to compare themselves to or model themselves on.

Ogunfowora (2014) considered social identity theory relevant to role modelling. Social identity theory explains intergroup behaviour (Tajfel and Turner, 1985) and provides an individual with a sense of who they are within a group. To improve self-image, individuals enhance the status of the group to which they belong and discriminate against those they do not by putting people into categories. Social categorisation is the first process of social identity theory, whilst the second stage is adopting the identity of the group to which individuals categorise themselves. Finally, social comparison takes place when individuals compare their group to other groups. Self-esteem occurs when comparison is favourable to the group to which the individual identifies. The principle of social identity theory relevant to role modelling is the belief that individuals are self-motivated to be positively distinct from others, they aim for a positive self-concept (Tajfel and Turner, 1985). This raises the question of whether individuals are self-motivated to aim for positive concepts of themselves.

4.2.4 Summary

Analysis of literature in this section provided insight to implicit meaning of the concept of nurses as role models in health promoting behaviour by identifying

uses of the term 'role model' across various disciplines. This provided a platform from which to analyse and develop the concept. Consideration was given to what role modelling is and the matter of being a role model, which included: being motivational, transmitting ethics, and demonstrating professional skills and conduct. Being motivational was identified similar to but different from being inspirational; being motivational encourages frequency of an activity and being inspirational encourages starting an activity. This suggests that in the context of role modelling being motivational only has an impact on those already engaged in a particular activity which resembles principles of inverse care law (Tudor Hart, 1971): people who access health care most are those that need it least. Implications for nurses as healthy role models are therefore to be inspirational and motivational. There is some disagreement whether individuals seek similarity in role models. Gibson (2004) predefined role models as cognitive constructions based on wants, needs and ambitions of the individual which implies individuals relate to different role models; one size does not fit all.

4.3 Methodological analysis of literature explicit to nurses as role models in health promoting behaviour (Step 3)

Chapter Two included a critical literature review of empirical evidence regarding nurses as role models in health promoting behaviour. The purpose of step 3 in the methodological framework was to identify defining attributes, antecedents and consequences within literature explicitly referring to nurses as role models in health promoting behaviour, rather than critical analysis. A table of 74 publications retrieved through this search provides an overview (Appendix 6). This stage of the process, as outlined in Chapter 3 included systematic retrieval of nursing literature to include: opinion pieces, editorials, scholarly articles, research studies and non-peer reviewed nursing columns (Figure 3.5). Findings, which resulted from reading and rereading literature, manually highlighting and labelling of documents are presented in this chapter. Some publications focused on role modelling more than others, evident from the instances the term occurred in the text; these contribute significantly to the

analysis (Blake and Harrison, 2013, Rush et al., 2010, Rush et al., 2005b, Clarke, 1991, Dalton and Swenson, 1986, Blake and Patterson, 2015).

4.3.1. Defining Attributes of nurses as role models in health promoting behaviour

Attributes are defining characteristics always present in the concept. Separating out defining attributes of a concept can be difficult because they overlap with related or similar concepts (Walker & Avant 2014). Clusters of attributes identified in the literature most commonly associated with the concept of nurses as role models in health promoting behaviour are outlined in Table 4.2. I was able to categorise these as: individual and societal, which are now presented. Societal relates to nurses perceived expectation or role within society.

Table 4.2: Defining Attributes of nurses as role models in health promoting behaviour

ATTRIBUTES	
<p>INDIVIDUAL</p> <p>Caring: empathetic, warm, sensitive, patient, intuitive, good communicator (connecting, listening)</p> <p>Non-judgemental: unconditionally accepting, non-patronising (not too obvious) and respectful (not arrogant)</p> <p>Trustworthy: consistent, congruent (sincere, genuine and authentic)</p> <p>Inspiring and motivating, encouraging, facilitating, empowering and knowledgeable</p> <p>Self aware: Self-confident, self-reflecting</p> <p>Self-caring: Manages stress, manages weight, non-smoking, ceasing smoking, taking regular exercise, has good diet, eats well, has adequate sleep.</p>	<p>SOCIETAL</p> <p>Portraying self as nurse in healthy way</p> <p>Being an exemplar: Practising what you preach/ living by example</p> <p>Championing health and wellness</p>

Individual Attributes

Personal qualities or attributes identified in the literature associated with being a role model in health promoting behaviour included the nurse being: a) caring b) non-judgemental c) trustworthy d) inspiring and e) self-aware.

Caring

Caring was often discussed as having empathy, warmth, sensitivity, and patience. Empathy, the desire to appreciate and understand another person's perspective, was frequently associated with the concept (Hicks et al 2008, Brown and Thompson 2007, Blake and Harrison 2013). A scholarly UK article (Clarke, 1991), focused on tension between the role of the nurse as a role model and health educator; recommending relationships with clients based on warmth, respect, genuineness and empathy were most effective in helping people make pertinent health choices. Rush et al (2010) included caring in the SARMHEP tool (Self as Role Model for Health Promotion), which was discussed in Chapter 2. Caring by being sensitive, intuitive and hope giving were advocated for community health nurses as role models in changing clients' lives (Glugover, 1987). The author (Marchiondo, 2014) of a scholarly article from the US asked if nurses were credible coaches in stemming the current obesity epidemic, suggesting attitudes marked by patience, encouragement, acceptance and trust were required by role models. Rush et al (2005b) identified many attributes for nurses as healthy role models including: being empowering, self-reflecting, trustworthy, being genuine, inspiring, self-awareness and caring.

Non-judgemental

Being non-judgemental and having unconditional acceptance of individuals was well represented as an attribute within the literature (Hagglund, 2009, Rush et al., 2010, Kinney and Erickson, 1990, Rush et al., 2005b). Such an approach was argued by Rush et al (2010) to model a non-traditional approach to health promotion rather than a traditional, prescriptive and authoritative approach. Other related qualities were: being non-patronising (Dunkley and Ward, 2005) and not being too obvious, arrogant or self-righteous (Curtin, 1986).

Trustworthy

Being trustworthy was identified in the literature as an attribute related to qualities of honesty, genuineness, being sincere or authentic (Marchiondo, 2014, Rush et al., 2005b, Rush et al., 2010, Clarke, 1991, Glugover, 1987). Trust is an essential component of nursing practice and is the understanding or belief that our good will be taken care of, putting faith in the good will of others (Pask, 1995). Nurses need to understand complexities of what might influence patients' trust, such as personal or cultural experiences to develop trust rather than distrust. Glugover (1987) used a student nurse's opinion to explain the part trust has to play in nurses as role models, illustrating the argument above that nurses should understand complexities influencing trust:

"I have developed much insight into illness and the various attitudes towards health and illness in the clients/families. I have also gained a respect and appreciation for differences in values. I realized how important familiar coping patterns and practices are to families and they must not be stripped away, but worked with in a way that promotes learning and trust in adaptive health-coping styles"

(Kelly O'Donnell in Glugover 1987: 48)

Inspiring and motivating

Participants in the Rush et al. (2005b) study described the ideal role model as a source of inspiration and motivation; this confirms work by Mutter and Pawlowski (2014) identified in multi discipline literature. Chambers and Thompson (2009) argued good role models are divergent thinkers with an approach to promoting health that is empowering. The focus on motivating behaviour change through empowerment in health promotion has been advocated since the Ottawa Charter on Health Promotion (WHO 1985). Empowerment can be defined as a process in which people gain increased control over decisions and actions affecting their health. Rush et al (2005a, 2005b, 2010) also identified being empowering and knowledgeable as relevant to nurse being role models.

Self-awareness

Having a sense of 'self' or self-awareness was identified as an attribute of

nurses as role models in health promoting behaviour (Clarke, 1991, Rush et al., 2005b, Borchardt, 2000). Learning about and developing a sense of 'self' was argued by Clarke (1991) as important for nurses as role models in health education roles; being a healthy role model is not just what she does but what she is being:

“more to do with internal mechanisms and self-sentiment rather than external behaviours. Nurses need to have the opportunity to explore where they stand in relation to the 'role' of the nurse. Development of a sense of 'self' is a good starting point.”

(Clarke, 1991: 1183).

Implications of the above quote suggest that internal mechanisms such as mental and spiritual health of nurses contribute to healthy role models. Clarke (1991) argued that self-image and self-confidence contribute to the credibility of the nurse as a role model. Self-reflection, giving thought to one's actions and character was considered an important component and personal domain in defining role modelling by Rush et al (2005b). Borchardt (2000) described self-awareness of self-care patterns an important step towards nurses helping others reach a high level of wellness.

Self-caring

Examples of self-caring qualities related to nurses as role models in health promoting behaviour, identified in the retrieved literature, regularly made reference to weight management and healthy eating (Roux et al., 2014, Blake et al., 2011, Rush et al., 2010, Denehy, 2008, Hicks et al., 2008, Connolly et al., 2013, Connolly et al., 1997, Blake and Patterson, 2015). Elements of self-caring included: managing weight, not smoking or trying to cease smoking, having regular exercise, having a good nutritious diet, having adequate sleep and managing stress. Roux et al. (2014) highlighted the prevalence of obesity expectations to be healthy role models. The justification for this feasibility study of a weight management programme was evidence that 50% of US nurses are overweight (Han and Trinkoff, 2011).

Blake and Patterson (2015) focused on attitudes of paediatric nurses towards healthy eating. An aim of the study was to assess nurses' opinions about being

role models in healthy behaviours. One finding identified weight management as an attribute; participants considered children and families more likely to heed health advice from a healthy role model and reported weight status as influential to how they were perceived. Blake et al (2011) evaluated a UK workplace wellness programme; weight management and exercise were identified as attributes. The programme measured physical activity, general health, smoking behaviour, diet and alcohol. The authors argued that pre-registration nurses should, as a population be appropriate role models in weight management and optimal exercise habits. Hicks et al (2008) US study found weight-appropriateness influential to instilling public confidence in nurses providing health education. Demonstrating good nutrition and regular exercise practices, managing stress and getting adequate sleep were considered necessary for school nurses who were argued to have an obligation to be healthy role models to children in an editorial article (Denehy, 2003).

Numerous authors made a link between nurses as role models in healthy behaviours and being non-smokers, not being seen to smoke or ceasing smoking (Moxham et al., 2013, Dao Thi Minh et al., 2008, Halcomb, 2005, Beletsioti-Stika and Scriven, 2006, Dunkley and Ward, 2005, Connolly et al., 1997). Moxham et al (2013) considered smokers as poor role models in a quantitative study investigating smoking rates within nursing and attitudes to supporting patients with smoking cessation. A further study investigating smoking patterns of Vietnamese health professionals claimed a need to “highlight the importance of improving and promoting beliefs of health professionals about being role models for patients by not smoking” (Dao Thi Minh et al., 2008: 7). The WHO’s code of conduct for health professionals (WHO, 2004), which includes a requirement to act as role models by not smoking is discussed by Halcomb (2005), who calls for role models to not use tobacco products and promote tobacco free cultures. Following a study examining smoking behaviours and motivation to quit in Greek nurses, Beletsioti-Stika and Scriven (2006) argued that only when nurses cease smoking can they be positive role models. However the same study found many nurses identified smoking as a strategy to manage stress. Denehy (2003) considered managing stress an attribute for being a healthy role model, arguing

this includes having adequate sleep to cope with nursing practice. Denehy (2003) further argued to be a credible healthy role model it is essential nurses are able to care for themselves while caring for others. O'Connor (2002) suggested nurse leaders also need to 'prioritise self', creating a healthy lifestyle and acting as workforce role models. The author argued a self-care regime for nurses could impact on patients because they truly experience what they ask their patients to do.

Societal Attributes

Further attributes of nurses as role models in health promoting behaviour can be linked to nurses perceived expectation or role within society: portraying self in a healthy way; being an exemplar to society by practising what you preach and living by example; and being a champion for health and wellness.

Portraying self in an a healthy way

Chalmers et al. (2003) examined smoking habits of 272 Canadian student nurses using a mixed methods approach. Students claimed to be aware of the need to portray themselves in a healthy way and felt hypocritical when smoking. Students reported RNs offering smoking cessation often smoked, considering this not good role modelling. Students in this study recalled being told at the beginning of their education that it was their responsibility to portray themselves in a positive light but felt confused about themselves as role models (Chalmers et al., 2003). The attribute of portraying self in a healthy way is further supported by self caring individual attributes previously discussed in this Section.

Being an exemplar

Over a quarter of the publications used the expressions: living by example; being an exemplar or practising what you preach in reference to nurses as healthy role models. Authors of a scholarly paper (Blake and Chambers, 2011) argued that nurses are public role models for health and should use knowledge they have to transfer to their own health behaviours: practising what they preach. A quantitative study (Jaarsma et al., 2004) conducted in the Netherlands investigated cardiac risk factors of cardiac nurses to test if they 'practised what they preach'. Findings confirmed they did heed their own advice and Jaarsma et al. (2004) considered them good role models for prevention

initiatives. A US quantitative study (DeMello et al., 1989) examining smoking prevalence found that 93% of participants felt they should set a good example by not smoking. The authors suggested increased support for nurses to embrace the 'exemplar role', using the term interchangeably with role model for healthy behaviour.

Championing health and wellness

Blake and Chambers (2011) highlighted an emerging role: the 'health champion', as a response to UK public health initiatives. The authors considered nurses should be exemplars and champions for health as the public views them as role models for health. Serving as a point of reference for positive health habits within society which may be imitated by patients was identified within the literature (Malik et al., 2011). Being a health champion was discussed with reference to role modelling in an editorial piece during National Nurse Week (Ball, 1997), prompted by a White House Reception when President Clinton spoke of nurses as leaders in promoting wellness and healthy lifestyles. Blake and Patterson (2015) argued: nurses are advocates for health, unavoidably role models, and effective role modelling means practising what you preach. Championing health and wellness within society was therefore identified as a societal attribute of nurses as role models in health promoting behaviour.

4.3.2 Antecedents of nurses as role models in health promoting behaviour

The next step in concept analysis was to identify antecedents and consequences. Antecedents are things that must be in existence before the occurrence of the concept: what is necessary before it can occur. Identifying antecedents is valuable in identifying underlying assumptions surrounding a concept. Antecedents of nurses as role models for health promoting behaviour derived from the retrieved literature are discussed in this Section. Antecedents are organised around individual, societal, organisational and educational aspects of nurses as healthy role models.

Table 4.3: Antecedents of nurses as role models in health promoting behaviour

ANTECEDENTS			
INDIVIDUAL	SOCIETAL	ORGANISATIONAL	EDUCATIONAL
Belief in health promotion and being a role model will have an impact and Valuing Self	Social and political activism Obligation to be role models Belief that nurses are knowledgeable Image	Supportive practical workplace initiatives Addressing factors that contribute to unhealthy lifestyles as coping mechanisms Nurse Leaders to be healthy role models	Understanding and application of health promotion in pre-registered nurses Understanding of health promotion in registered nurses

Individual Antecedents

Individual antecedents identified in nursing literature included beliefs in health promotion and that being a healthy role model can have an impact. Valuing self by embracing health and valuing your own health were also identified.

Beliefs

Rush et al (2010) suggested being a role model in health promoting behaviour requires an approach to health promotion that includes individual belief that being a healthy role model can have an impact on the health of others. Believing in health promotion itself was identified as necessary:

“nurses who believe in health promotion and embrace healthy behaviours are more likely to be healthy role models”

(Esposito and Fitzpatrick, 2011)

Dao Thi Minh et al. (2008) compared knowledge, beliefs and attitudes of 2151 health professionals towards smoking using a WHO adapted survey. Findings

demonstrated those who believed they could influence the behaviours of their patients by being role models were also three fifths less likely to smoke.

Valuing self

Nurses need to value their own health in order to be healthy role models (Denehy, 2008). Valuing self is an antecedent, which Rush et al (2010) incorporated into the SARMHEP (The Self as Role Model for Health Promotion) tool to appraise motivation for healthy behaviour practice amongst nurses. Denehy (2003) considered it essential to care for oneself to be able to care for others, further arguing in the editorial that self-care is essential to being a role model in health promoting behaviour. In contrast, Rush et al. (2005b) argued that a person could value their self as an imperfect role model by accepting less than perfect lifestyles. Clarke (1991) argued some nurses might feel their credibility diminished because of certain lifestyle behaviours: the credibility is not in what they do but in who they are. Nurses should recognise their strengths relevant to being role models, discovering a positive aspect of themselves, which fits with being a role model, and feel good about the discovery (Clarke, 1991). This alternative standpoint from which nurses can approach their health promotion activities supports arguments from Rush et al (2010). However, both standpoints included valuing self as an antecedent to being a role model.

Societal Antecedents

Societal antecedents comprised of: an obligation for nurses to be a role model, public belief that nurses are knowledgeable, positive image of nursing and nurses being socially and politically active in society.

Social and political awareness

Rush et al's (2005b) qualitative research of the nurse as an imperfect role model made reference to nurses being politically and socially active. The authors cited a health promotion text which highlights social-political activism for role models essential in health promotion (Tones, 1992).

Obligation

An obligation infers moral or legal obligation and in an editorial Denehy (2003) infers there is a professional obligation for school nurses to be healthy role

models to address the health problems of the population. This view supports the professional obligation and statutory requirement.

Positive image of nursing

A further antecedent concerned nurses' image and position in society. Borchardt (2000) argued nurses need an image of credibility with the public to be role models, in-line with Festinger's (1957) attitudinal theory. Borchardt (2000) argued the public needed to perceive role models as competent, powerful, and attractive, further asserting that nurses who do have such credibility and role modelling add credibility to health messages provided. There is evidence that the image of nurses is considered important to many (Blake and Harrison, 2013), therefore images such as being seen smoking in public should be avoided. A US study (Dalton and Swenson, 1986) examined role modelling in relation to nurses' smoking behaviours and found 96% of 601 participants considered nurses had to be perceived as knowledgeable people within society in order to be role models.

Organisational Antecedents

Many authors referred to organisational issues as antecedents for nurses as healthy role models. These included; workplace support for healthy lifestyle, addressing workplace stress and nurse leaders as healthy role models

Workplace support for healthy lifestyle

Many practical examples were presented of the workplace supporting healthy lifestyles as antecedents to nurses being healthy role models. Most focused on smoking cessation and organisation role in supporting nurses to cease smoking and become healthy role models. While some believed that policies should be in place to address nurses smoking, targeting them for education (Dao Thi Minh et al., 2008, Halcomb, 2005), others suggest offering support through accessible clinics and cessation classes (Slater et al., 2006, Pollard, 2004, Baron-Epel et al., 2004, DeMello et al., 1989, Dalton and Swenson, 1986, Connolly et al., 2013).

Organisational responsibility to provide healthy available food for nurses was considered necessary for nurses to be healthy role models (Blake et al., 2011,

Eggertson, 2013). This included canteens providing access to hot healthy food for shift workers (Naish, 2012) with consideration given to low calorie options (Roux et al., 2014). Some suggested providing free, healthy snacks to clinical areas for busy nurses and deliveries of low cost, healthy boxes (Zapka et al., 2009). Other initiatives included fitness classes and programmes, cycle to work schemes and work sports tournaments at various times to suit shift work (Naish, 2012, Zapka et al., 2009, Blake et al., 2011). Sporting initiatives required suitable facilities for showering provided within the working environment (Trossman, 2013).

Address workplace stress

Stressful working environments contribute to stress leading to unhealthy coping mechanisms such as smoking, which Beletsioti-Stika and Scriven (2006) demonstrated in their study of 402 Greek nurses. Eggertson (2013) considered bullying, violence and lack of respect in the workplace needs addressing together with challenges recognised in working shifts in a twenty-four hour, seven days a week organisation. Trossman (2013) reflected on the US healthy nurses programme in a short article, arguing being bullied leads to nurses developing unhealthy coping mechanisms and policies reducing workplace stress were necessary.

Nurse leaders as healthy role models

O'Connor (2002) argued in a scholarly article that nurse leaders need to make changes and be role models by prioritising 'self'; creating a healthy lifestyle. The impact on staff watching nurse leaders make such changes in the healthcare culture creates a healing environment for staff, patients and nurse leaders themselves (O'Connor, 2002). Hicks et al (2008) examined the link between public confidence in nurses' ability to provide health education and body size, citing O'Connor's argument above to provide a background for their study.

Educational Antecedents

Many authors made reference to educational antecedents for nurses as healthy role models. These focused on two main factors: understanding and application

of health promotion in pre-registered nurses through the curriculum, and understanding of health promotion for RNs through training.

Understanding and application of health promotion in pre-registered nurses

Holt and Warne (2007) argued that a curriculum that prepares student nurses with wider knowledge about health promotion, to develop confidence and skills, which can be applied in practice, is essential. It is necessary that the knowledge gained from health promotion education is transferred to nurses' personal lifestyle behaviours (Blake et al., 2011).

Improving personal health, where necessary during nurse education was considered important by several authors who discussed diet, alcohol consumption, exercise programmes and initiatives for pre-registration nurses (Blake and Chambers, 2011, Blake and Harrison, 2013, Yeh et al., 2005, Kamwendo et al., 2000). Undergraduate nurses find various ways of coping with the stress of nurse education and work stressors therefore supporting students' mental health and helping them develop healthy coping mechanisms is crucial during education for them to be healthy role models (Timmins et al., 2011). Shriver and Scott-Stiles (2000) found the theoretical content of nursing curricula could impact on health behaviours of students in a mixed methods longitudinal study. The authors argued that emphasis on self-care and the importance of being good role models is required for students to subsequently become role models. Blake and Chambers (2011) argued for the importance of setting standards for health behaviours early in the nursing career.

Understanding of health promotion for registered nurses

Greater understanding of health promotion for nurses was identified as an antecedent to being role models in health promoting behaviour. Training and education for RNs should include smoking cessation (Warren et al., 2008) and healthy diet (Malik et al., 2011) where appropriate. Blake and Chambers (2011) considered a structured educational training in health promotion a requirement for RNs, pre-registered nurses and other health professionals to become workplace health champions.

4.3.3 Consequences of nurses as role models in health promoting behaviour

Consequences are incidents or events occurring as the result of the concept. Walker and Avant (2014) suggest that identifying the consequences of a concept often identifies neglected ideas and relationships, which might subsequently lead ideas and direction for new research. Consequences discussed in the literature were themed as individual, societal and organisational consequences. Many of the identified consequences are suggestions from authors reflecting their own views and opinions because very little empirical evidence is available of the consequences of nurses as healthy role models.

Table 4.4: Consequences of nurses as role models in health promoting behaviour

CONSEQUENCES		
INDIVIDUAL	SOCIETAL	ORGANISATIONAL
Improves personal health. Helps nurses cope with stress of profession. Potential stress by the burden of expectation.	Nurses seen as leaders and champions in public health. Behaviour change in others. Reduces population risk factors. Positive influence on health of public	High quality patient care. New generation of public health workforce. Delivery of government policy (UK and International) Validates and gives credibility of advice (patients more likely to heed advice)

Individual Consequences

Blake and Harrison (2013) demonstrated nurse training does not always influence health behaviours. However earlier research indicated learning how to be a good role model in health promoting behaviour during nurse training

had a positive impact on personal health habits of student nurses (Shriver and Scott-Stiles, 2000). Malik et al (2011) considered nurses being role models in healthy behaviours, including physical exercise might equip them to cope with stressors of the profession. A counter-argument was: being healthy role models can create personal stress to nurses by the burden of the expectation (Rush et al., 2005b, Blake and Patterson, 2015, Pollard 2005).

Societal consequences

A debate in the nursing press between Dobinson, Harrington and Cornforth (2006) suggested nurses being role models in health promoting behaviour offered the opportunity to be viewed as leaders and champions in public health. This in turn could have the consequence of a positive effect on overall health of the public (Dalton and Swenson, 1986). Influencing public behaviour by bringing about behaviour change is viewed as a consequence of nurses being healthy role models by many authors (Roux et al., 2014, Moxham et al., 2013, Merrill et al., 2010, Shriver and Scott-Stiles, 2000, Dalton and Swenson, 1986, Eggertson, 2013). Such changes in lifestyle behaviours were considered to impact upon reducing risk factors in the general population (Jaarsma et al., 2004, Aucoin, 1986).

Organisational consequences

Blake et al (2011) made a link between nurses as healthy role models and delivery of government health policy. Malik et al (2011) argued nurses are uniquely placed to be healthy role models and therefore support the delivery of UK and international health policy. Blake and Chambers (2011) proposed that with training nurses could become workplace champions for health, resulting in a new generation of public health NHS workforce. Blake and Harrison (2013) examined health behaviours and attitudes to being healthy role models in student nurses. They argued their findings demonstrated UK pre-registered nurses recognised the importance of personal health behaviours and how this may influence the quality of patient care. Participants mostly considered their lifestyle would influence whether patients would heed advice which the authors link to improving patient care (Blake and Harrison, 2013). Anything impacting on patient care is of significant consequence for health care organisations.

Several authors considered nurses as healthy role models add credibility or validity to advice being given (Dunkley and Ward, 2005, Ball, 1997, Holt, 2008, Blake and Harrison, 2013, Blake and Patterson, 2015). Such credibility of those providing health advice reflects well on the organisation in which they work.

Understanding gained from this concept analysis of literature provided perspectives congruent with initial understanding of the concept. However, “maintaining a tentative posture with respect to a selected definition is necessary if the investigator is to be open minded in the refinement process” (Schwartz-Barcott and Kim, 2000: 137). It was clear at this point that while the main consensus of understanding around the concept involved nurses having healthy behaviours one conflicting view emerged: the imperfect or ‘humanised’ role model which is outlined in the following section.

4.3.4 Related cases: the imperfect ‘humanised’ role model

Related cases found within data obtained from fieldwork or literature (Walker and Avant 2014) are connected to or similar to the concept being studied, sharing some but not all defining attributes. Developing related cases helps us understand the complexity of the subject being studied. Examination of related cases provided clarification to what fits with the concept under analysis and what does not.

Several authors referred to the concept of the imperfect role model (Rush et al., 2005b, Rush et al., 2010, Sarna and Percival, 2002, Eggertson, 2013, Kamwendo et al., 2000, Blake and Patterson, 2015). Arguments for nurses having unhealthy behaviours included:

“those nurses who are ‘unhealthy’ are actually able to provide a better level of care. They have a greater capacity to empathise with their patients since they are suffering from the same or similar conditions” (Dobinson-Harrington and Cornforth, 2006).

To ignore diverse opinions and arguments surrounding the complexities of nurses as role models in health promoting behaviour would oversimplify current understanding of the term. Can nurses be good role models in health promoting behaviour by modelling unhealthy behaviours and being imperfect role models?

Rush et al's (2005b) provided discussion on this phenomenon and considered it a 'humanistic' definition of the term. The qualitative study explored how nurses described themselves as role models and reported negative and positive views of the 'idealised role model'. It is the 'idealised role model' for which the preponderance of defining attributes has been identified in this concept analysis of literature. Defining attributes identified for the 'humanistic, imperfect role model' were: being on the same level, being equal, being authentic, and using flaws to motivate behaviour change. The views of participants in the Rush et al (2005b) study challenged the perception of the ideal role model and supported the authors' argument that being a perfect role model may impede nurses promoting health. A view held by some, cannot be ignored:

"If you look at Oprah Winfrey, now people love her because she is just like them. She's getting fat again. But everyone is right there with her. They identify with her. They identify with her because she is a real person, and I think that's what we are too"

(Rush et al 2005b: 175)

Findings from a recent study examined paediatric nurses opinions about being role models; supported the imperfect role model view (Blake and Patterson, 2015). Participants (82%) believed if their health behaviours were seen as those of a 'real' person rather than an ideal one, patients would have more connection with them. However, Blake and Patterson (2015) raised a point about this finding for consideration. There appeared to be inconsistency between actual lifestyle behaviours of participants and their reported attitudes towards the importance of being role models. The authors suggested this inconsistency between beliefs and behaviours might be due to a form of cognitive dissonance (Blake and Patterson, 2015).

An antecedent to the concept of the imperfect role model was found in the work of Rush et al (2005b). The authors argued for a nurse to be a role model in health promoting behaviour, they must first accept themselves with imperfections. Despite the authors arguing a case for the imperfect role model they consider the primary way effectiveness as a health promoting role model is determined is through personal lifestyle behaviours (Rush 2005b).

Acknowledgement that the imperfect role model is inconsistent with the general consensus of role modelling was the justification for identifying the imperfect or humanised role model as a related case. Rush et al (2005b) considered the consequences of an ideal role model can be destructive by conveying a false reality to patients, which may result in an aggressive, condemning, and arrogant attitude in nurses. Subsequently this can cause a sense of superiority and separation between nurse and patient.

4.3.5 Summary

A concept analysis of retrieved literature provided insight into opinions, values and beliefs about the concept of nurses as role models in health promoting behaviour. Individual articles provided information for identifying defining attributes, antecedents and consequences, however no collective analysis has been published to identify them as such. Attributes, antecedents and consequences were organised around individual, societal, organisational and educational aspects of nurses as healthy role models within this chapter. The theoretical stage of this study therefore provided original work in providing clarity, meaning and understanding to a concept. This understanding highlighted the degree of consensus among users of the concept, which helped to define a concept (Schwartz-Barcott and Kim, 2000).

Chapter 5: Qualitative Findings Fieldwork Phase

5.1 Introduction

This chapter presents thematic analysis of fieldwork (Steps 5 &6). The aim of the fieldwork phase was to investigate student nurses, nurse educators and RNs experiences and perceptions of role modelling health promoting behaviour. Findings from the thematic analysis are presented with supporting narrative and participant quotes for seven emergent themes and subthemes (Table 5.2). The final concept analysis of qualitative data is presented in Chapter Six.

5.2 Participant profile

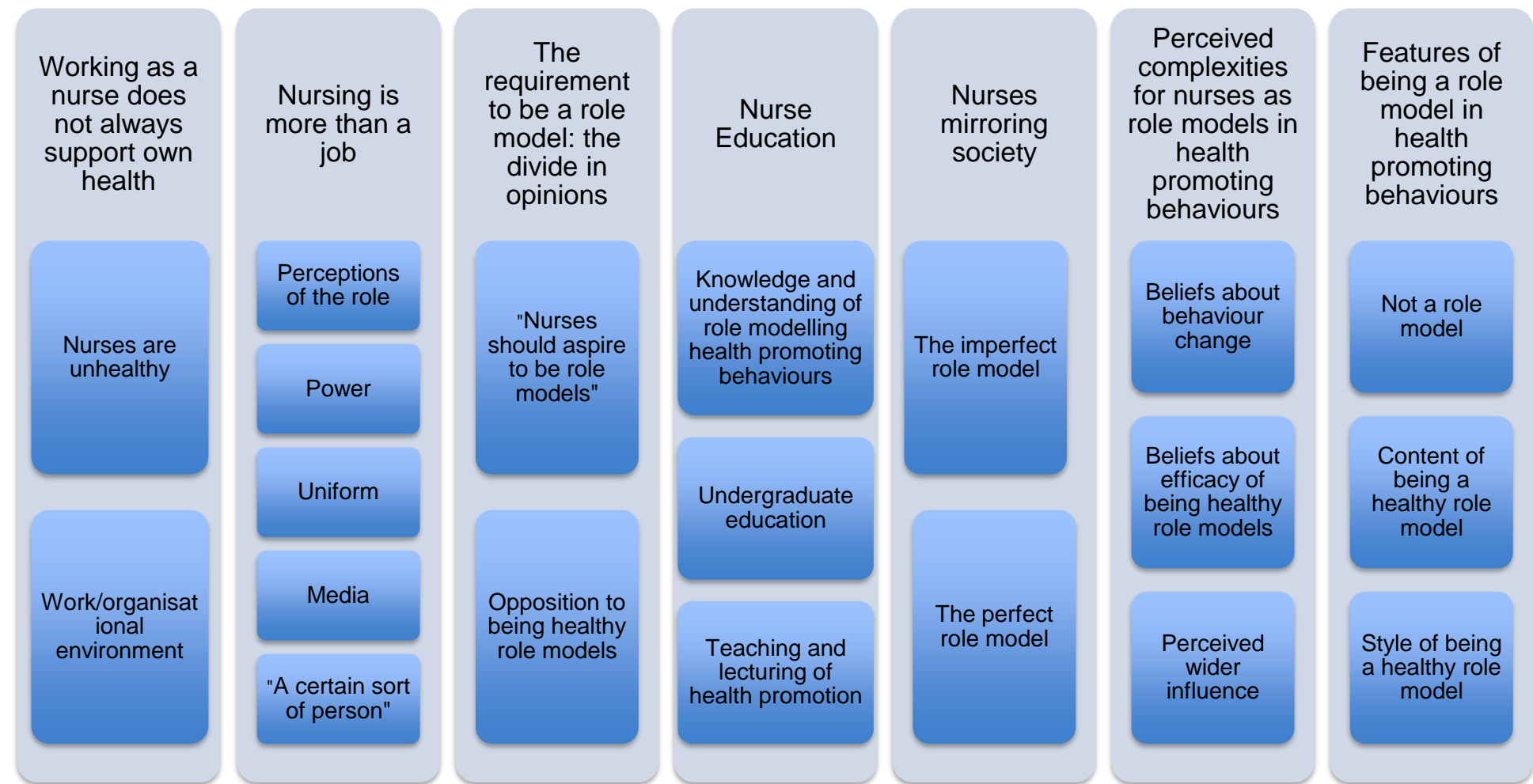
Thirty-nine participants, across six focus groups and one interview were recruited; eighteen student nurses, thirteen RNs, and eight educators (mean age 33, range 21-58, 74% white, 8% male: Table 5.1). In 2008 10% of the nursing population were male (Vere-Jones, 2008) which suggests this sample is representative of the current nursing population. Recruitment of nurse educators proved problematic so a final focus group was organised which resulted in one volunteer. A one to one interview was therefore conducted and included in findings. Collecting and including data from the one to one interview respected the wishes of the individual to participate but also provided me with an opportunity to reflect on the suitability of the chosen data collection method through focus groups. The interview did not lead to any new themes but supported previous discussions. The interaction between multiple participants resulted in elaborate discussions and reflections across a range of views beyond the level of discussion provided in the one to one interview.

Table 5.1: Participant profile

Focus Group	Participant	Registration status/branch/dept.	Sex	Age	Ethnicity
1	1	Pre-registered (PR)	F	48	Black British
	2	PR	F	34	White British (WB)
	3	PR	F	27	White
	4	PR	F	30	White
	5	PR	F	22	WB
	6	PR	F	21	Black African
	7	PR	F	38	WB
	8	PR	F	39	White
2	9	PR	F	29	Mixed. White/Asian
	10	PR	F	22	WB
	11	PR	F	31	White
	12	PR	M	25	WB
	13	PR	F	29	Mixed. Black Caribbean/Polish
	14	PR	F	24	White British
	15	PR	F	21	White British/French
	16	PR	F	28	WB
	17	PR	F	33	WB
	18	PR	F	21	WB
3	19	Registered. Child. A&E	M	29	WB
	20	Registered. Adult. Primary Care.	F	48	White
	21	Registered. Adult. Acute Medicine	F	23	Black
4	22	Lecturer-palliative care	F	58	WB
	23	Lecturer-community	F	43	WB
	24	Lecturer-Primary care	F	53	British (Irish)
5	25	Lecturer-Adult. Intensive Therapy Unit.	F	57	White Irish
	26	Lecturer-Learning Disability	F	57	White
	27	Lecturer- Child	F	54	White

Focus Group	Participant	Registration status/branch/dept.	Sex	Age	Ethnicity
	28	Lecturer-Adult Acute Care	F	40	White
6	29	Registered. Midwifery	F	34	White
	30	Registered. Adult. Accident & Emergency	F	37	White
	31	Registered. Child. Day surgery	F	33	Black
	32	Registered. Adult. Day surgery	F	52	White
	33	Registered. Mental Health	M	36	White
	34	Registered. Midwifery	F	34	WB
	35	Registered. Adult. Theatres	F	-	Asian
	36	Registered. Midwifery	F	39	Black British
	37	Registered. Midwifery	F	32	White
	38	Registered. Adult	F	58	Black
(Interview) 7	39	Registered. Advanced Nurse Practitioner. Primary Care	F	55	WB

Table 5.2: Thematic map



5.3 Theme: Working as a nurse does not always support own health

There is substantial evidence within the data that participants consider working as a nurse does not support them to be healthy:

(FG6). *“The work itself does not support our own health sometimes. So how are we supposed to promote it if the work that we believe in we are going past our duties, giving our all of ourselves but then the work in return makes us ill.” (Everyone nods.)*

This theme provides insight to nurses' experience in practice and what they have observed of nurses encouraging health-promoting behaviour through role modelling. The theme includes issues surrounding participants' perceptions of the health of nurses, unhealthy coping mechanisms, not having breaks and work or organisational issues. These perceptions are organised and discussed under two subtheme headings: nurses are unhealthy and work/organisational environment.

5.3.1 Nurses are unhealthy

Frequent reference was made to poor health of nurses; implications and observations expressed. Study participants shared many experiences to demonstrate they considered nurses unhealthy because they do not always take care of themselves. Participants considered: nurses *“not role modelling health promoting behaviours are commonly seen”*, nurses themselves require good role models in health promoting behaviour and health promotion advice should be aimed directly at nurses to improve their health. Feeling burnt out and stressed were identified as problematic to nurses' health and participants considered they had 'lost their way' due to work pressures. Participants considered barriers to good health exist within the working day, such as unhealthy working relationships. Two groups considered the constant supply of unhealthy gifts from patients a barrier to good health (FG1&3). External pressures such as family commitments and personal issues were described as contributing to general health and wellbeing. Lecturers (FG3) suggested student nurses often gained weight upon qualifying and high alcohol intake was a factor influencing health of some nurses.

Participants suggested nurses should be leading healthier lifestyles for themselves rather than for the benefit of patients. They considered shift work a barrier to the ability or desire to be role models in health promoting behaviour:

(FG6) “a lot of people do smoke.... and don’t eat particularly well however on the flip side of that I would say often those habits are the result of unsocial shift patterns”

Some participants considered it easy for nurses to develop bad practices and not be good role models. Furthermore, nursing was considered tough and developing personal resilience not always easy. Participants suggested many nurses develop unhealthy lifestyles as coping mechanisms for the stresses of the job:

(FG4) “So the stress that I had in my first sort of five years of being qualified, that’s when you develop your coping mechanisms and your perhaps unhealthy lifestyles”

Reported unhealthy coping mechanisms due to pressure of being a nurse were identified as: comfort eating, smoking and alcohol consumption.

5.3.2 Work/organisational environment

Participants volunteered extensive opinions concerning the impact of employment or organisational issues on nurses’ health. The workplace was discussed as a barrier to nurses being healthy role models. Some participants found the workplace ‘unhealthy’ and felt more able to be healthy away from work:

(FG1) P1- “I’m healthier at home than in the hospital”.....P2- “because it’s too stressful an environment”.....P3 “I think as you were saying the ward environment is a stressful place to be and it’s not the place to be focusing on your health because you can go a whole shift without drinking water without eating properly, you come home and you’re ravenous and you eat junk food but then if you’re not working the next day you’ll probably eat better”

Barriers to being healthy were identified by participants as: lack of time, workload, responsibility and finances. Findings revealed many nurses do not have access to healthy food or drinking water at work, which appeared to make them feel unsupported and undervalued:

(FG5) “You can’t have ice machines because gets taken and you can’t have a water fountain because it’s too much money and the vending machine is only available at some trusts at weekends because they’ve had to close them, so you have to go to the petrol station to a sandwich for dinner. They don’t look after their staff; they don’t have this culture that we’re looking after you.”

Every group considered lack of sufficient breaks on duty relevant to their health, relating lack of breaks to ability to act as role models. Inadequate staff ratio was often considered the cause of the problem. However, having a break was not always considered part of organisational culture:

(FG1) “But the way the system is set up with the long shifts, the short breaks, you know sometimes you don’t get the breaks, I don’t know how you can be expected to role model healthy behaviour when you’re not given the time to look after yourself properly”

Participants reported recurrent episodes of cystitis or urinary tract infections due to not urinating during shifts. Claims of not having a break to drink, urinate or eat within a twelve-hour shift were not considered uncommon:

(FG3) “We had a mother bring a child in because the child hadn’t passed urine in eight hours and it was only at the end when I realised that I hadn’t been in twelve.”

Participants made a link between poor diet and weight issues: nurses just grab whatever they can, whenever they can. Lack of breaks and tiredness were cited as contributory factors to unhealthy eating habits:

(FG6) “You often see overweight health professionals and that is because you go hours and hours without a break and suddenly you get a break and there’s a chocolate doughnut in the office and your bodies telling you to eat that and you do. I’m just kind of explaining why you see it”

However, abstaining from taking a lunch break was often personal choice due to external pressures such as family commitments or second jobs. Some nurses choose to skip breaks to leave work slightly earlier and this appeared to be accepted practice in some work environments:

(FG5) “I think if you had access to a decent meal break because in a lot of places a lot of nurses forgo their meal break so that they can

leave early and do something else, you know do their second job, whether that's looking after a family or an actual other job in order to get money because they may be the bread winner"

Practical recommendations were made to provide healthier working environments including increased workplace support for mental health, counselling and smoking cessation. These suggestions corroborate organisational antecedents identified in literature (4.2.2.). However, participants raised the issue of accessibility rather than provision of support. Participants considered alcohol cessation support in one trust impractical due to shift work, suggesting workplace initiatives should be more accessible. Inconsistency of facilities across trusts was described and identified as barriers to healthy lifestyle:

(FG4) "mostly it's an unhealthy environment, whether it's about access to the outside, whether it's about access to healthy food, whether it's about a shower so that if you wanted to cycle in, there are barriers there which would stop people thinking about a healthier lifestyle"

Many participants considered the organisation was not looking after staff and employers should take more responsibility for nurses' health. Nurses did not feel valued by employers and felt employers did not care. Participant's linked feeling undervalued to their health:

(FG6) "they are not getting thanks from management or the payment is not saying well done, you've done a great job this month so you know those sorts of factors can affect you"

(FG7) "The employers are irresponsible generally and they don't care. You think about some professions that you go into and you are looked after by your employer. We have a huge healthcare force in this country and I don't think it's looked after by employers whether you're working in a general practice or you're working in a nursing care home, or a ward in a hospital, the community.... I think the employer must take more responsibility"

Three focus groups considered working as a nurse does not support personal health and feeling undervalued in the working environment was related to this

(FG4,5&6). Student nurses however did not feel undervalued. One group of nurses (FG6) discussed such feelings at length appearing very demoralised and stressed, as they described never being listened to or thanked in their roles. I was concerned that discussions could have exacerbated feelings of being undervalued, therefore I facilitated a motivational debrief before leaving. Their lecturer for the day reported that they returned to lecture “bouncing”, they had thoroughly enjoyed participating. Further evidence of feeling undervalued included participants’ views that the government does not care about health of nurses for themselves but only the impact that it can have on others:

(FG4) P1-“by saying we want to support nurses because we love nurses or because we care about you”

P2“So then by doing that they will be these role models”

P3“Exactly”

P4“But the government is focusing on it in the wrong way”.

Participants clearly wanted to feel more valued and cared for by organisations. They perceived this as relevant to the ability to become role models in health promoting behaviour. One lecturer suggested valuing staff and providing a good work environment enables nurses to be healthy role models. She considered nurses less valued today than in the past:

(FG4) “When my mum nursed, they got all their food, they got their uniforms washed, they got shoes bought for them, they had a very different view of valuing staff”

5.4 Theme: Nursing is more than a job

Participants considered nursing to more than a job; it involves taking on a persona and connecting life to work:

(FG1) “a profession that involves people and it is vocational, at the end of the day it’s not just a job”

Subthemes of ‘nursing is more than a job’ include perceptions of role, power, media and uniform. Participants considered a “certain sort of person” enters the profession, discussed as relevant to being a healthy role model.

5.4.1 Perceptions of the role

Perceptions of nursing and the image of the profession were considered relevant to nurses being healthy role models. These included behaving or being perceived as professional which some described as innate and felt nurses mostly behave professionally. Being a health professional involved having consistent behaviour at work and personal lives:

(FG6) "I am not making a difference between outside and inside, professionally or privately, because I think the work that we are in, the way we have been educated, it shows. I think the nurses if they do not want to behave professionally then they are not professional themselves because that is innate."

Health professionals were described as held in high regard within society and often looked to as exemplars. However, some felt a pressure to meet public expectations to be healthy role models:

(FG7) "I think there is a lot of pressure on us to be role models.....you know you can't tell me not to smoke because you smoke yourself and I saw you. So I think maybe there is some pressure [researcher asks "from?"] The public...if you're not healthy why should we be?"

(FG6) "We (society) hold health professionals in such high regard"

In contrast others felt nurses were considered non-academic and believed not all patients required nurses to be role models in health promoting behaviour. Furthermore, there was discomfort in the perceived image of nurses:

(FG5) "I think the general public's view of the nurse is still this antiquated, paternalistic fashion, they don't want any of us to have degrees and they don't want any of us to be clever they just want us to give this old fashioned nursing care, you know, hand maiden to the doctor. So I know I feel really reluctant to fulfil the view of the general public because I don't think I like what they think of us"

Perceptions of nursing and the image of nurses as pictures of perfect health were cited with mixed views about whether the image of the healthy nurse was helpful. Being seen to be good role models by being fit and healthy was perceived as important to the image of nursing to some:

(FG1) *"The way in which patients perceive nurses is different in the way in which we think patients ought to perceive us. So I think that I do agree that being fit and healthy is part of being a good role model"*

In contrast many considered that people perceive the image of the profession not by appearance, but by how nurses treat people.

5.4.2 Power

Issues surrounding perceived power of the profession emerged as relevant to nurses as role models in health promoting behaviour. Some nurses considered themselves the 'face of the NHS'; in a prime position to be role models:

(FG2) *"I think it's [role modelling] crucial, it's really important. Nurses are the face of, you know the NHS, and in a hospital environment they are the patients' first point of call if you like to have role modelling. If you've got a nurse looking after you that you don't see as a role model in anyone's eyes then I don't think, it's going to be a positive environment"*

However, participants questioned the power they have to bring about change, particularly from a political perspective and reported organisational resistance to suggestions for change. Nurses reported feeling disempowered and isolated:

(FG5) *"I think sometimes well often as nurses working across the board you feel quite powerless.....the system is broken, it isn't working as well as it could do so nurses become, they feel quite disempowered"*

Feeling powerless, not having a voice or not being heard, can be linked to feeling undervalued which was discussed in relation to working as a nurse does not always support health (Section 5.3). Lecturers (FG4) considered nurses being politically aware as valuable and related to being healthy role models, however they considered many were not interested. Participants did not feel as highly regarded as doctors within society and often felt unable to contradict doctors, which raised issues of power surrounding the profession:

(FG5) *"they hold him in high esteem because he's [the doctor] the man with the answers.and so far as nurses are concerned, are you saying that society holds nurses as health professionals in high esteem?.....With some regard but not as high"*

One lecturer (FG4) claimed nurses need to feel empowered to pass on knowledge about healthy lifestyles, explaining they often feel disempowered because the organisation does not meet the complex needs of many patients. Student nurses reported often feeling powerless or disempowered, unable to challenge RNs, which stifled aspirations to be healthy role models:

(FG2) “when you do go into a workplace and there is a certain attitude and a certain way that nurses work it’s kind of that you don’t want to stand out and student nurses don’t want to stand out because they want to be accepted. Or even if they do seem really keen to do it [role modelling] and then the environment around them is not like that at all, they end up kind of doing the same……. Yeah it’s kind of like you’re being stifled in a way”.

5.4.3 Uniform

Issues about uniform were discussed in relation to role modelling health promoting behaviour. Participants considered putting on a uniform elicited a recognisable responsibility to behave a certain way; to ‘play the part’:

(FG1) “I often feel I am playing a role in a way, when I put on my uniform I am like “I am nurse [name] now I am going to be health promoting, no one is going to see me smoking, my behaviours and this kind of thing. I’m not going to use bad language all these sorts of things.” I am going to model a sort of image”

Some felt the uniform previously commanded respect from the public, however it was no longer influential; society has moved on. The lack of distinctive nursing uniforms was considered to contribute to this. Participants suggested the public are often unaware of the difference between RNs, and other HCP’s. A limited impact of nurses being healthy role models was implied if the public couldn’t tell the difference between a nurse and a cleaner:

(FG5) “they can’t tell who’s the staff nurse, who’s the sister, who’s the healthcare assistant, they’ll complain about the nursing care but if you ask who said that to you or who did that, was it the nurse, they have no idea”

Implications of uniform regulations including tattoos and piercings were discussed. Consideration was given to how the public perceive the image of a nurse with tattoos and a link made to not judging nurses by appearances:

(FG6) “we have talked about piercings or tattoos and stuff like that. Now people will have lots of them and may be absolutely amazing at what they do and there may be some with nothing and look like an absolutely great role model but actually they are not approachable”

5.4.4 Media

Participants discussed the influence the media has on nurses being role models in health promoting behaviour. Participants considered media representations of nurses more negative than positive and suggested that the media could be useful in presenting a positive image of nurses as a healthy role models:

(FG 6) “the media just like to portray the bad messages and actually don’t have the exposure of the good stuff”

One group of RNs (FG3) discussed at length the impact on public health of nurses being role models and suggested producing public health videos with positive images of nurses. Participants discussed social media and the relevance of nurses managing social networking accounts to maintain professional image:

(FG6) “through social media which is almost open to anyone in the public. So if you were more of an acquaintance with someone on face book and they were a nurse and they were always talking about their late nights and maybe hinting at drug taking behaviours and things like that it might make you think that it doesn’t fit with the image of a healthy professional “

Participants did not acknowledge the existence of NMC guidelines for social media guidance (NMC., 2015) for behaving professionally and protecting the public.

5.4.5 “A certain sort of person”

Participants considered a “*certain sort of person*” is attracted to entering the profession, which was discussed in the context of nurses being role models in health promoting behaviour:

(FG6) *“We’ve gone into these professions and role because this is the sort of person we are”*

Being healthy role models was considered innate by some because of the sort of people they were. Participants described individuals who are attracted to the job as caring and nurturing, often who are ‘givers’ in nature and suggested they need to care for themselves sometimes by “giving in” rather than constantly “giving out” (FG4). Some participants discussed the ‘sort of person’ attracted to nursing brings ‘*baggage*’

(FG5) *“coming into nursing, and having done it relatively recently within the last 15 years, it is stressful, it is a huge change in your life, you come to these things and you have baggage, everyone does”*

The nurturing quality of women was considered a reason for nurses often putting themselves last, due to other caring responsibilities such as family (FG4).

5.5 Theme: The requirement to be a role model: the divide in opinions

During the first focus group I became aware that participants did not know about the NMC requirement for nurses to be role models in health promoting behaviour. I therefore included a brief question in all subsequent interviews, which confirmed my suspicions: with the exception of a few lecturers most participants were unaware of the NMC requirement. Discussions in all focus groups presented a divide in opinions within the profession surrounding the requirement to be healthy role models, supporting mixed and opposing views discussed in Chapter 2:

(FG2) *“I think there is a divide, not so much in abilities but in the want to be that kind of thing” [of being a role model]*

Opposing views surrounding the requirement to be healthy role models are now presented. These views meet the research objective to explore factors nurses

perceive to affect their ability or desire to act as role models in health promoting behaviour.

5.5.1 Nurses should aspire to be healthy role models

Many participants considered being a healthy role model an obligation for nurses, which should be their aspiration. Some felt the NMC requirement serves the purpose of informing expectations to those entering the profession. They considered role modelling important, that most nurses are healthy role models and others hope to achieve this:

(FG1) "I think it's good as something to aim for though, it strikes me as something that you should always try to do"

Participants predicted a positive impact of being healthy role models and considered people more likely to change behaviour if they saw nurses as role models (FG2&7). Some considered that health-promoting advice does not work if the person giving advice is not 'doing the same thing'. People will take more notice of advice from a positive role model; it helps to see that nurses look after themselves:

(FG2) "I just think that health promotion would be like more effective if people were acting as role models. I think that there is more chance that the person will receive it and try and make a change if they can actually see that person as a role model rather than not"

Participants considered being healthy role models would contribute to changing the health of the nation by addressing the obesity crisis. Improving patients' outcomes by improving lives, health and quality of life were also identified:

(FG3) "Well hopefully you could have a big impact....you could help with the obesity epidemic"

(FG5) "The best scenario is that we change the health of the nation with people that come into contact with healthcare professionals, nurses"

Examples of individuals described as poor or negative role models were used to support arguments for nurses being healthy role models. One group was unable to describe a good role model, but described many that were not. A RN

used personal experiences to explain the potential impact of a negative role model:

(FG6) “My dad was diagnosed 5 years ago with COPD, he is 70 now and the doctor that he used to go to is a smoker, so my dad all the time kept saying “why should I give up cigarettes, the doctor smokes and he is fine, yes I am ill but I am not going to die right now so I am not going to give up”

5.5.2 Opposition to being healthy role models

In contrast to views in Section 5.5.1 other participants criticised the requirement to be role models in health promoting behaviour and considered the requirement unrealistic, unfair and asking too much:

(FG1) “the code is unrealistic and is unfair on nurses because why are nurses being placed in this position when they are everything to everybody when no one else has to be?”

Some were angry about the statutory requirement, suspicious of the motives behind it and considered it to be making nurses ‘agents of the state’ working to a government agenda:

(FG4) “I’m angry about it

[researcher] You’re angry?

Yes.....I’m not totally against the thought that we should be role modelling but it’s where is that actually coming from? What’s the rationale behind it? You know, is it to try and save money, or in terms of patients is it your fault because you do this”

RNs, students and lecturers perceived being a healthy role model added another pressure to a profession already struggling to cope with workload. Some considered it low priority in acute clinical settings and questioned whether being a healthy role model is relevant in all situations:

(FG3) “they’re really ill and so for me health promotion is the last thing on my mind, I just want to get them to a stable condition and move on to what’s next”

Some considered being a healthy role model of “*minimum consequence*” (FG6), appeared ambivalent about it and felt verbal advice provided by nurses had most impact. Some participants perceived they were being told how to live

their lives, which they felt angry about. Participants explained why they felt some just 'switch off' to being healthy role models, perceiving it as a government driven agenda in a climate where fulfilling their role was tough:

(FG4) "the thing is as soon as you see that, you said it is part of our, what is it? It's part of our NMC you said. A lot of people will switch off to that, they just switch off because the grass roots work is emotional, it's tough, people are frightened about their jobs, they've really been hounded the last five years so when the government comes out with another thing, it's just like yeah whatever, just carry on and do what I do, how dare you tell me how to live my life, it feels like that"

Some participants felt it unfair for the nursing profession to be singled out to be role models in healthy behaviours arguing a joint responsibility for the multidisciplinary team:

(FG1) "I think it is unfair, it's not just unrealistic but it's unfair because when you are delivering care, you're not delivering it in a vacuum you've got other health professionals."

Lecturers (FG5) used examples of other professions to express feelings of unfairness, arguing that bad businessmen or accountants can have a negative impact on people's lives but are not expected to be role models. Participants provided many examples of perceived negative consequences of the expectation to be healthy role models, including a blame culture resulting in nurses feeling guilt or failure. One participant questioned if they would be failing in their role as a nurse if they had unhealthy behaviours. Subsequent damage to morale of the profession and reduced interest in recruitment was discussed:

(FG1) " P1-they see themselves as failing, if you don't or you are not meeting this requirement which they say is your role then you've failed....

P2-Yeah because the expectations are so high. It damages the image of the profession as well doesn't it?

P3-Mmm, yes. If the standards are too high for us to meet

P1-But that will also damage morale because if I'm not meeting it what's the point you know? Maybe I just take the attitude- this is just too hard for me, I can't possibly do that, what's the point I might just as well give up.....

P2-What you were saying is true about morale dropping and you will get even less people coming into the profession”

Concerns regarding entry to nursing were raised by a group of lecturers (FG4) with a different perspective. These individuals interview applicants for entering the profession and voiced concerns about potential recruitment discrimination based on applicants’ weight. RNs shared this concern, considering it impossible to measure a good role model and considered it enforced upon them:

(FG3) “The thing is, how would they enforce it, how would they measure whether you are being a good role model, you know are they going to stop you practising as a nurse if your BMI’s over 35?”

Some held the image of the perfect role model and considered being a healthy role model unachievable, because “*perfection is not achievable*” (FG2). Being perfect and ‘putting nurses on a pedestal’ featured frequently in discussions. These points can be linked to arguments surrounding advantages and disadvantages of nurses mirroring society (Section 5.6). Participants considered nurses on pedestals could be perceived as patronising by the public and they were concerned about professional image if they fell off the pedestal:

(FG 4) “I’m very concerned about this idea about.....that nursing professionally is on a pedestal, we’re up here and there are all these lovely people promoting lifestyles and you lot down there, it’s that sort of pedestal, and then we can fall off the pedestal very quickly”

Reasons given for nurses choosing not to be healthy role models included: the right to your own life and keeping work and private life separate. Some considered it personal choice rather than a professional requirement. One group of RNs (FG6) considered being healthy role models a paternalistic approach to improving health:

(FG6) “I think some people just think, do you know what I’m just not interested, I just want to do my job and go home, whether I’m role modelling health behaviours I either don’t care or do you know what it’s my choice to not. So long as I do my job well and I’m safe that’s kind of...role modelling health promoting behaviours is the least of my worries”

5.6 Theme: Nurse Education

Participants perceived issues relating to education relevant to the concept of nurses as role models in health promoting behaviour. Subthemes discussed in this Section include: knowledge and understanding of role modelling health promoting behaviour, undergraduate education, and teaching and lecturing of health promotion. Discussions included specific educational requirements and practical suggestions for nurse education. This theme addressed the research objective to explore whether student nurses, RNs and nurse educators perceive the educational experience prepares students to meet the requirement to role model health promoting behaviour.

5.6.1 Knowledge and understanding of role modelling in health promoting behaviour

Many participants expressed lack of understanding of what is meant by role modelling or health promotion. Two groups, students and lecturers immediately requested a definition of role modelling health promoting behaviour. Every group expressed difficulty in understanding the concept. Although FG3 did not verbalise lack of understanding directly they demonstrated confusion by engaging in lengthy examples of health education approaches such as teaching mothers to breast-feed. The concept appeared to be open to individual interpretation and participants expressed the need for a clear definition:

(FG1) "Role modelling personally health promoting behaviours, mmm that's the sentence.....I think that's the thing that will have to be defined"

One group of lecturers (FG4) considered the use of language not helpful in understanding the concept: if the concept was reframed as '*developing resilience*,' nurses would be more likely to "*sign up*" to being healthy role models. This suggested some nurses were not in favour of being role models, which is linked to the divide in opinions discussed in Section 5.5.

Students and RNs discussed health education appearing confused by the meaning of both. Having heard the term health promotion in the introduction many discussed situations, they considered being health promotion: teaching patients how to wash their hands or explaining why pressure area care was

provided which demonstrated lack of understanding. Lecturers had a clearer understanding but reported lack of knowledge or understanding about health promotion within the profession:

(Int 7) "I think sometimes people don't even understand what we mean when we say health promotion; they think what are you talking about? Are you talking about health improvement or protecting yourself, protecting your health?"

Constantly changing guidelines and clinical evidence were considered difficult to keep up with causing confusion and lack of understanding for many nurses. RNs identified a need for education to remind them of the role they play with patients in promoting health and a general updating in general health promotion education, with particular focus on knowledge about how to take care of themselves. Students considered existing RNs required updated knowledge in health promotion to encourage them to be healthy role models:

(FG2) "I don't think it's nursing students that are the problem, it's nurses that are already out there because we've had loads of health promotion and I feel that it is the older generation in the hospitals currently"

5.6.2 Undergraduate education

One student nurse (FG1) succinctly explained that students *"just need a little bit more education"* to support them in becoming healthy role models. Participants made recommendations for undergraduate nurse education, suggesting the interview process should consider whether candidates would be potential positive role models:

(FG2) "make it a bit more personal so that they get more of a vibe of your beliefs, how you think, whether you are going to be that good role model..."

Lecturers (FG4) suggested many students lacked personal resilience to complete nurse education and felt they required further support to develop resilience. Participants considered resilience is developed through learning about yourself, which should be addressed in education through self-healing. A lecturer used an example of story-telling and exploring spirituality to *"think through self-healing"* (FG4), while another argued that *"sorting out your own*

mental health” (FG5) provides personal insight, which contributes to becoming a healthy role model. This appears to be linked to previous points that the profession attracts a ‘certain sort of person’ (Section 5.4.5), which included findings that some nurses are thought to enter the profession with ‘*baggage*.’

Lecturers made critical observations that first year students’ knowledge of basic healthy lifestyles and behaviour change was limited. All three groups of lecturers (FG4, 5 &7) discussed a theory practice gap concerning health promotion in general: either what is taught in universities is not transferred to practice or the ideal is taught which does not compare with reality. One student nurse (FG1) described attending a study day on smoking cessation with a nurse consultant and then witnessing the nurse behaving contrary to principles taught on the study day on returning to practice. One group (FG1) considered they were taught about health promotion as a subject but not taught “how” to actually promote health. RNs also perceived a theory practice gap:

(FG6) “Actually I think that’s really tricky because what you learn in theory, it doesn’t always transfer in practiceeven when you go into placement. The placements are there to help you see what you are going into because you are working on the ward, you are seeing exactly how it should be but when you are outside of that practical setting the messages don’t always marry up, so I don’t know, the link needs to be tighter”

Discrepancy in what is taught and what takes place in practice was identified as a barrier to nurses becoming role models in health promoting behaviour. Specific examples were not provided, however suggestions of how to address the discrepancy were discussed. Lecturers suggested students need to feel empowered to challenge workplaces, taking what is practised throughout education into clinical practice:

(FG4) “if you get into cooking something for yourself, having a little walk at lunch time, and you do it here [university], then they need to be empowered when they go back into practice and are leaders, they are going to be leaders of services and leaders of teams, and they can be nagging the places that they go out and work”

Lecturers (FG4&7) suggested working with health promotion agencies would address the theory practice gap enabling students to see health promotion activities in practice. Being involved with environmental health activities was identified as helpful during education. More reflection on practice was considered necessary in education with further experiential self-learning opportunities such as yoga and mindfulness. The need for health education for students themselves was discussed in relation to being role models in health promoting behaviour. One suggestion considered the concept of being a role model should be included in students' assessment and appraisal procedures (FG2).

Participants made critical observations about the current pre-registration nursing curriculum. Lecturers considered the curriculum predominantly focused on developing skills and competencies, medically orientated and designed in a reactionary manner, reacting to current high profile health issues:

(FG5) "So we seem to sort of move with the next big pressure and maybe the next big thing is going to be obesity and then we will devote, you know we haven't got much time in the curriculum as it is, and we'll throw out a few things and put a bit of that in and then a year later it'll be whatever is the next crisis"

However, one lecturer argued nutrition and issues concerning obesity were not provided with enough focus throughout the curriculum despite a focus on obesity in public health. Health promotion content was described as incoherent throughout the curriculum. Several lecturers suggested health promotion could be better integrated throughout the curriculum and include more current public health research. Many lecturers acknowledged adding to the curriculum is challenging however recommendations were made for inclusion of health promotion from the outset, integrated throughout, rather than taught in isolation. One lecturer suggested input on self-care would be most valuable after students had some clinical experience to ensure it had meaning.

5.6.3 Teaching and lecturing of health promotion

Many students considered lecturers were positive role models for healthy behaviour, providing them with an example of what they aspired to be. Students

identified favoured teaching strategies for health promotion including more experiential learning and teaching through simulation. However, some lecturers felt a pressure within their role, which they considered a barrier to integrating more health promotion into their teaching content:

(FG4) “one of the reasons why we haven’t introduced as much experiential stuff like all those things that used to go on, is because of the pressure now. To be a lecturer now there is this pressure around your research, around your academic side, your scholarlyness, your clinical side so nurse educators for want of a better word... there are so many pressures on everyone.”

Students and lecturers felt lecturers have a pivotal role to play as healthy role models to student nurses.

5.7 Theme: Nurses mirroring society

Some participants expressed the belief that nurses mirror society and share the same problems and health issues as everyone else, thus considering it a lot to ask of the profession to be healthy role models:

(FG1) “it’s a big one to put on professionals who mirror society.”

All groups made reference to this theme and participants expressed contrasting opinions about nurses mirroring society. Some considered it useful to share the same problems and struggles as patients to whom they offer health promotion advice, feeling more comfortable defining themselves as less than ideal. This is consistent with the idea of the imperfect humanised role model: the related case discussed in Chapter 4 (Section 4.3.4). In contrast others considered nurses mirroring society and sharing similar health issues was unhelpful, disagreeing with the idea of the imperfect or humanised role model. The debate surrounding nurses mirroring society is presented in this Section as two subthemes: the imperfect role model and the perfect role model. This theme is relevant to the aims and objectives of the research question to investigate and explore nurses’ experiences and perceptions of role modelling health promoting behaviour.

5.7.1 The imperfect role model

Being able to empathise with people or relate to them was cited as the main advantage to nurses being representative of the general population:

(FG5) "The NHS is the biggest employer therefore it must be representative of normal people and I think that's what makes us empathise with people."

Most discussions about nurses mirroring society focused on smoking and weight issues. Some nurses felt struggling with these issues provided personal insight, which patients appreciated. Participants felt better able to relate to patients by sharing unhealthy behaviours:

(FG1) "I've had some experience with people who feel that perhaps being on the larger side or people who smoked or people who don't necessarily partake in what might be classed as ideal if you like....feel that they are better able to relate to their patients."

Some felt having shared the same struggles and successfully changed behaviour produced a nurse, better at promoting health. Thus, they considered a nurse a better role model if they had previously been overweight or smoked:

(FG3) "I think if you've been through the process of cutting down drinking, or stopping smoking or getting more active you know, all these kind of things, it makes you a better health promoter because you know the struggles that it involves"

Other nurses considered the image of the perfect nurse unhelpful and argued for nurses to mirror society. Looking too fit or healthy was argued to have a negative impact on patients:

(FG4) "you could put certain patients off because someone [who] looks very lithe and fit and thin is telling someone that you shouldn't do this and you shouldn't do that and they think you know, sod you sort of thing. It could make the patient more defensive and have the opposite effect"

One RN who worked on a respiratory ward questioned her credibility to be a role model in her clinical area because she had never smoked and could not empathise. She perceived that patients recognised she only gave health advice regarding smoking cessation because she had to:

(FG3) “So it’s quite hard because I can’t empathise, no I can advise them but they know that I am just doing this because I just have to tell them because I won’t understand. If I was an ex-smoker and I myself quitted smoking, then that would be a different story”

5.7.2 The perfect role model

In contrast other participants considered sharing or mirroring certain unhealthy lifestyle behaviours a barrier to being a good role model. Smoking and being overweight were identified as barriers to nurses discussing smoking cessation and weight management with patients:

(FG7) “They feel that they are not very good role models themselves. So if they do not feel a very good role model they may feel that they can’t give advice about something that they can’t do themselves. So I smoke...can I really tell you to stop smoking?”

Some nurses felt mirroring society and sharing unhealthy behaviours could impact on losing trust from their patients because patients might not believe advice provided:

(FG6) “we are saying to the patient oh you should give up smoking because your lungs are in danger of having cancer or COPD but then nurses are doing that and coming back to patients so patients are losing trust in us.”

Many nurses disagreed that sharing similar health struggles and behaviours facilitated being a role model by creating empathy. One lecturer explained it was difficult to ask nurses to give advice about weight management when they may have low self-esteem caused by being overweight:

(FG5) “to get someone who has really low self-esteem who is overweight, who is a really caring nurse and actually to say to them you are going to talk to someone about health promotion because they are over-weight and they’ve had an MI, it’s tricky isn’t it”

5.8 Theme: Perceived complexities surrounding nurses as role models for health promoting behaviour

Participants considered various factors, which illustrate perceptions that improving healthy behaviour in patients is more complex than nurses being healthy role models:

(FG6) "I think there is a lot more to it, it's not just as simple as that. It will have some impact and I think that it's good that we try to role model healthy behaviours but I think there is so much more to why people make choices about their health than just because your nurse or midwife or doctor is doing something or not doing something"

Subthemes discussed in this Section provided further insight to nurses' perceptions of role modelling health-promoting behaviour, which include; beliefs about behaviour change, beliefs surrounding efficacy, and the perceived wider influence of healthy role models.

5.8.1 Beliefs about behaviour change

Without exception each group made reference to complexities of behaviour change as relevant to the impact of nurses being role models in health promoting behaviour. Students, RNs and lecturers all discussed personal beliefs about behaviour change. Many references were made to people having to be ready for change which one RN argued as necessary before a nurse could be perceived as a healthy role model:

(FG3) "where a patient may want to kind of change but yeah I think the patient has got to want to change before the nurse is a role model."

One RN argued many people do not care about their health; they have different priorities in life. Others argued nurses as healthy role models may have some impact changing behaviour on a subconscious level. Students and lecturers held the belief that there is a '*right moment*' or '*window of opportunity*' to influence behaviour change. Lecturers considered by choosing the wrong time to discuss health behaviours it could be perceived as blaming individuals for their poor health. One RN suggested people should take more responsibility for their own decisions while others in the group argued that patients are

autonomous; can make their own decisions regardless of nurses' health behaviours:

(FG6) "I think that other things will make up somebody's mind. They are autonomous they will make their own health decisions throughout life but whether a health professional doesn't do something isn't going to change them. I think other things will decide how they behave"

The same group considered people choose positive or negative role models to support decisions surrounding their choice of lifestyle. If they want to smoke and see a nurse smoking they will adopt the *"they smoke so it must be fine"* attitude. This group suggested negative messages are more readily received than positive. Further points made about behaviour change included the belief that scaring people about health does not make a difference.

5.8.2 Beliefs surrounding efficacy of nurses in health promoting behaviour

Nurses perceived the impact or potential impact of being role models in health promoting behaviour dependant on certain parameters or factors. Amount of contact time or frequency of contact with individual patients was argued to influence impact:

(FG5) "So I don't think from the acute perspective that patients are in our care long enough or we don't have enough exposure to influence them"

Many nurses questioned the impact they can have on individuals with insufficient contact time. Reference was made to the need for a good therapeutic relationship to have impact as a healthy role model and many linked this to contact or exposure time. A further point raised was the impact of nurses as healthy role models as dependent upon the audience. Reference was made to patients being individuals; while one nurse might have an impact as a role model to one person, another may not wish to improve their health. Student nurses and lecturers considered cultural diversity linked to efficacy of nurses as healthy role models, acknowledging that cultural attitudes toward body image vary across cultures. One student nurse referred to her own African culture to illustrate this: her family encouraged her to maintain a weight which

western culture considers unhealthy. Clearly one size of role model does not fit all.

5.8.3 Perceived wider influence

RNs (FG6) considered being healthy role models could have an impact in a wider context within the community to include colleagues, friends and family. Students, RNs and lecturers discussed a snowball or ripple effect; having an impact on a few can escalate to have an impact on many (FG3, 4 & 7). They did not underestimate the impact of each individual relationship:

(FG2) “I mean you can’t change the whole world but you could start with one person and if they actually see that they are changing their lives they can do it to someone else and someone else and it could have a good impact. You can just start with one”

One participant explained the potential impact of nurses being healthy role models required a top down and ‘grass roots’ approach: raised political profile and statutory requirements, plus an individual impact at ‘grass root level’ of health care. RNs (FG3) considered being healthy role models to children and young people could have the greatest impact, before poor health behaviours become habits.

5.9 Theme: Features of being a role model in health promoting behaviour

Participants described actions and behaviours associated with being a role model: ‘what you do’ and ‘how you do it’. Participants provided examples, which offered insight to the perceived personal qualities and characteristics required to be a healthy role model. Information provided addressed the aims and objectives of the research question to explore nurses’ experiences in practice and perceptions of role modelling health promoting behaviour. Subthemes include: ‘not a role model’, content (what you do) and style (how you do it).

5.9.1 Not a role model

In response to being asked what they understood by role modelling health promoting behaviour, many participants found it easier to conceptualise ‘not being a role model’. Discussions surrounded examples of negative behaviours,

which provided insight into barriers to nurses being healthy role models. For example, communicating was previously identified as integral to role modelling in the literature (Sections 4.2.2.2. & 4.3.1); participants identified poor communication skills as 'not' being a good role model. One lecturer argued poor communicators should be removed from the front line because they do a disservice to nursing by creating a poor first impression. Another lecturer identified lack of confidence as a barrier, explaining many nurses lack confidence to improve health behaviours and engage in new physical activities. One student nurse considered complacency could develop as a result of supporting patients trying to bring about behaviour change:

(FG1) "I think also that there is the potential to become complacent within our role, so we say well I've tried but this person doesn't want to change so why should I bother?"

Most discussions surrounding nurses not being role models in health promoting behaviour focused on smoking, obesity and alcohol consumption. Many references were made to nurses smoking, being seen smoking or smelling of smoke:

(FG2) "A couple of times I've been on wards and when they do go out to have a cigarette and stuff they come back and they actually do smell quite bad, like the stale cigarette smell. So if they are speaking about all this health promotion stuff and actually smelling of that it's not the greatest"

Being overweight was not considered being a healthy role model for two reasons. Firstly, many argued the impact of this observable measure of health, the visual impact on patients and general public as relevant to being a healthy role model. One lecturer made observations of overweight nurses and described it as a current health dilemma:

(FG5) "There were young women [nurses] opposite me who were all obese, in as much if use that very coarse way of measuring your BMI, so 25/26 but they weren't around a BMI of 26 they were around a BMI of 30/35, you know good looking, young, relatively healthy looking but they were big. I think for patients in our care, particularly families when people come in as a result of their co morbidities and

they are morbidly obese and when you look at the staff you think gosh there are a lot of obese nurses here. There is a bit of a health dilemma going on here”

Secondly, some considered being overweight impacted on the nurses’ physical ability to perform their role. Nurse obesity was argued as detrimental to both nurses and patients. Struggling to walk quickly in response to an emergency crash call was claimed to be a concern in one example. Poor diet and being seen in hospitals carrying fast food bags was also considered an example of not being a healthy role model. Nurses, doctors and midwives were described as not eating well. One student nurse described nurses coming to work smelling of stale alcohol and appearing hung-over, which they considered unprofessional.

Many participants provided examples or described saying one thing and doing another. Expressions such as *‘being a hypocrite’* or having contradictory behaviours were used. Examples of providing smoking cessation advice and proceeding to smoke were described as giving the wrong message. A lecturer considered such situations a moral issue; she did not feel she could talk to a patient about health behaviours unless her own behaviour was consistent with advice being given. One group of student nurses linked seeing evidence of unhealthy behaviours to patients not trusting nurses:

(FG2) “I just don’t think patients trust the nurses’ input if they can’t see it for themselves, or they think it’s a bit hypocritical”

Certain personal characteristics or attributes were perceived as not being a good role model. Others described what you ‘should not be’ as a good role model in health promoting behaviour. Discussions therefore identified attributes due to points made of poor role models. For example, by discussing being judgmental as poor role modelling one can derive the participant implied being non-judgemental was an attribute. Participants described being patronising as poor role modelling, which implied being un-patronising was considered an attribute. Not telling people what to do and *“ramming information down people’s throats”* (FG4) emerged as consistent with being non-authoritarian as a good role model. These attributes will be further discussed in Chapter 6. A

contrasting argument was presented by one RN who considered being a role model in health promoting behaviour was not about an individual's own healthy life. This argument can be linked to the theme 'perceived complexities of nurses as role models' (Section 5.7), previously presented in this chapter:

(FG3) "so I don't think it is a concept that is just about an individual, you know this idea that we are expecting students and nurses to role model what this healthy life looks like. I think that is too individualistic and we have got to look at it broader than that"

5.9.2 Content of role modelling health promoting behaviour

Examples of actions associated with role modelling health promoting behaviour included: listening, guiding, communicating and empathising. Connecting with people, working 'with' patients, developing a therapeutic relationship rather than just providing advice were all identified as contributory actions. Seeing health problems and potential improvements to behaviour from the patients' perspective rather than being prescriptive was considered:

(FG2) "Kind of taking the time to listen and getting it from their perspective of the problem and getting their thoughts about how they would want to go about it"

(FG5) "You have to have insight into the other person's situation"

Participants associated passing on knowledge and advice, encouraging and providing support with being healthy role models. Most definitions of role modelling do not include being giving advice but participants considered this relevant to the role. Providing encouragement and support was considered a guiding process; avoiding telling people what to do:

(FG2) "I think it's kind of steering away from telling the person what to do and saying, "what you are doing is wrong and you should be doing this". It's more of a guiding process"

Most nurses described healthy role models as inspiring and leading by example or being exemplars in healthy behaviour. As previously discussed there is a debate by some that it does not always mean being fit and healthy; nurses who are unhealthy relate to people and have empathy. However, for most, whether

they agreed with being healthy role models or not, the term inferred being fit and healthy:

(FG1) "So I think that I do agree that being fit and healthy is part of being a good role model"

All groups inferred or stated that 'what you do' as a healthy role model is practise what you preach. Being prepared to have positive health behaviours and 'doing what patients ought to do':

(FG3) "Well very simply it's about doing what you are telling others to do. Showing that you actually live the behaviours that you are expecting your patients to adopt"

P2- You mean like setting an example?

P2- Yeah

Despite agreement that being a good role model involves not being authoritarian the use of language in the quote above appears contradictory. Further examples described 'telling people' or referred to what people 'ought' or were 'expected' to do. There appears to be a discrepancy between what participants say and the language used:

(FG7) "If you're telling someone to exercise and eat healthy and not smoke that's really what you should be doing too"

(FG6) "Yes I think that's right we shouldn't tell patients what to do or what to try to do if we are doing those things"

Previously (Section 5.6), a lack of understanding about the use of the term role model and health promotion in general were discussed. When asked to explain understanding of role modelling health-promoting behaviour many participants confused it with teaching patients. They provided lengthy examples of explaining and demonstrating care, such as hand washing, as 'what you do' as a healthy role model. Such confusion supported the argument that the concept requires defining.

5.9.3 Style of role modelling health promoting behaviour

Participants discussed behaviours of being a healthy role model, which demonstrated nurses' perceptions about 'how' to be a healthy role model. Many references were made to behaving professionally or being professional by behaving in a certain way:

(FG5) “So a lot of talk about being professional and I think you expect a professional to behave in a certain way so it’s tied in with that”

Behaving in a professional way included nurses being honest about their own behaviours while respecting boundaries such as discussing and sharing personal behaviours and health struggles in an appropriate manner. Being honest and having integrity by believing in what they say was considered essential to a nurse being a healthy role model. Participants suggested this involved more than saying the right thing. It involved believing in what they say, being authentic:

(F1) “Just not seem as if you are reading from a script, that you believe in what you are saying..... Whether you’ve been a smoker or never been a smoker if you just sound as if you are reading from this.....yeah, integrity, having some authenticity”.

Respecting individuality was recognised by many as integral to a healthy role model; everyone has different experiences, values and approaches to health. The concept that one size does not fit all was previously discussed (Section 5.8.2). Recognising individuality creates a relationship of mutual respect and can be portrayed when the nurse is speaking to an individual about health changes:

(FG3) “if I show them that I am talking to them as an individual not just as a patient, then they will be able to see the changes that they can make because they are understanding you straight away”

Being realistic was considered necessary as a good role model, which can be linked to respecting individuality and much of the behaviour discussed in this Section. One participant identified respecting dignity as an example of how to be a healthy role model and explained that while having conversations about potential health behaviour changes the nurse should respect privacy. This could be argued as relevant to all nurse patient communication. Being an advocate or catalyst for change in healthier lifestyles was considered how to be a healthy role model. Some participants suggested nurses should not focus on individuals; the profession should campaign for changes to improve people’s health. Being active in health promotion was considered to encompass having impact at a level which enables individuals to make easier health choices by default:

(FG4) "I think the role model is not about the individual but that nursing can argue and advocate and articulate for change to make it easier for people to live healthily"

Participants discussed other personal qualities in direct response to one topic guide question: can you identify characteristics or personal qualities, which could be associated with the concept of role modelling to encourage health promoting behaviour? These included being: passionate, enthusiastic, inspirational, charismatic and positive, sensitive, caring, gentle and approachable, open, knowledgeable, innovative, creative and flexible. A need for personal self-awareness and resilience were also discussed as attributes of a healthy role model.

5.10 Summary

This chapter presented thematic analysis of the fieldwork phase of the study. Focus groups provided rich data, which captured registered nurses', students and nurse educators' perceptions surrounding the current meaning of the concept of role modelling health promoting behaviour. Some participants found it difficult to define being a role model in health promoting behaviour.

The thematic analysis provided insight to factors perceived to affect the ability or desire to act as healthy role models. Thus it provided insight to certain individual, educational and organisational issues surrounding the requirement to be role models. The qualitative phase of this work therefore went beyond analysing the concept to provide meaning and explored underlying complexities to develop further understanding about the concept. Findings from this chapter were carried forward to the final analytical phase of the study.

Chapter 6: Final analytical phase

6.1 Introduction

The methodological framework for this study was designed to combine theoretical analysis of literature with empirical data gathered from focus groups; the process of combination and integration of these different sources is the focus of this chapter. The final analytical phase included re-examining transcripts following thematic analysis to identify attributes, antecedents and consequences, which were subsequently compared to those, previously identified in literature (Section 3.5.5). Defining attributes, antecedents and consequences identified in qualitative data predominantly supported and refined those identified in the literature however further considerations were identified and are firstly presented in this chapter. A final table of combined antecedents, attributes and consequences is also presented (Table 6.1) with a key to illustrate the source of data: cross discipline literature (C), nursing literature (N) and qualitative findings (Q). Findings from both the theoretical and fieldwork phases are discussed in line with recommendations to “step back from the intensity and details of fieldwork and re-examine findings in light of the focus of interest” (Schwartz-Barcott and Kim 2000: 147) to consider: i) the relevance of the concept, ii) if the selection of the concept seems justified, and iii) to what extent the theoretical and empirical analysis supports the presence and frequency of the concept within the population under study. During analysis of literature and qualitative data a note was made of model, borderline, related and contrary cases. Notes were considered and papers and qualitative data revisited to identify cases and empirical referents, which are finally presented in this chapter. Nursing literature and qualitative findings provided most evidence for concept analysis, however some triangulation with cross discipline literature is included.

Table 6.1: Defining Attributes, antecedents and consequences of nurses as role models in health promoting behaviour

Key

C- Cross discipline literature

N- Nursing literature

Q- Qualitative data

ANTECEDENTS	DEFINING ATTRIBUTES	CONSEQUENCES
<p><u>INDIVIDUAL</u></p> <ul style="list-style-type: none"> • Belief that being a healthy role model can have an impact (NQ) • Valuing Self (N) putting yourself first sometimes (Q) • Empowerment (Q) <p><u>SOCIETAL</u></p> <ul style="list-style-type: none"> • Social and political awareness (NQ) • Obligation (NQ) • Positive image of nursing (NQ) <p><u>ORGANISATIONAL</u></p> <ul style="list-style-type: none"> • Workplace supports healthy lifestyle (NQ) • Address workplace stress (NQ) • Nurse leaders as healthy role models (NQ) • Feeling valued (Q) <p><u>EDUCATIONAL</u></p> <ul style="list-style-type: none"> • Understanding and application of health promotion in pre-reg nurses (curriculum): addressing personal health/healthy coping mechanisms (NQ) • Understanding of health promotion (through training) for registered nurses (NQ) • Clear definition of role modelling health promoting behaviour (NQ) • Personal resilience and self-healing (Q) 	<p><u>INDIVIDUAL</u></p> <ul style="list-style-type: none"> • Caring (NQ) gentle, sensitive and approachable (Q) empathetic • Non-judgemental (NQ) realistic (Q) • Trustworthy (NQ) honest and open (Q) transmit ethics (C) • Inspiring and motivating (CNQ) positive, charismatic and passionate (Q) • Sense of self (NQ) Self-awareness, self-reflection, self confidence • Self-Caring (NQ) resilient be fit and healthy (Q) • Knowledgeable and self-confident (NQ) • Innovative, creative, flexible (Q) • Professional (QC) <p><u>SOCIETAL</u></p> <ul style="list-style-type: none"> • Portraying self in a healthy way (NQ) being fit and healthy • Being an exemplar/ practice what you preach (NQ) • Championing health and wellness (NQ), being an advocate for change (Q) 	<p><u>INDIVIDUAL</u></p> <ul style="list-style-type: none"> • Improves personal health (NQ) • Helps cope with stress of profession (N) • Potential stress by burden of expectation (NQ) <p><u>SOCIETAL</u></p> <ul style="list-style-type: none"> • Nurses seen as leaders and champions in public health (N) • Behaviour change in others (NQ) patients, friends, family and colleagues (Q) • Reduces population risk factors (N) addresses obesity epidemic (Q) • Change health of Nation (NQ) positive influence on health of public (N) • Improves lives, health and quality of life (Q) <p><u>ORGANISATIONAL</u></p> <ul style="list-style-type: none"> • High quality patient care (NQ) improves patient outcomes (Q) • New generation of public health workforce (N) • Delivery of government policy (N, Q) • Validates and gives credibility of advice (NQ) patient more likely to heed advice (Q) • Impact on nurse recruitment by setting standard not all wish to meet (Q)

6.2 Final analysis of qualitative data

Antecedents identified within qualitative data, not previously identified in literature included: empowerment, feeling valued and addressing personal health through developing personal resilience and self-healing. Students did not feel able to challenge RNs whom they felt were not positive role models (Section 5.5) and considered this a barrier to being healthy role models themselves. This was corroborated by lecturers who were aware of the challenges graduating students will face and considered empowerment necessary for students to challenge workplaces, and transfer healthy practices encouraged in education to practice. An additional antecedent of 'feeling valued' within the organisation was identified in the qualitative data because participants considered feeling disempowered a barrier to being healthy role models and linked feeling undervalued by their organisation to their health (Section 5.3.2). Furthermore, they reported feeling powerless to influence change within their organisations (Section 5.4.2) and considered nurses less valued today than in the past. Feeling undervalued was also reflected in participant perceptions that the focus on nurses as healthy role models is motivated by the potential impact on others rather than the potential benefit for nurses. Improving personal health and developing healthy coping mechanisms where necessary during nurse education was considered 'application of health promotion' within the literature and programme initiatives discussed in Section 4.3.2 (Blake and Chambers, 2011, Blake and Harrison, 2013, Yeh et al., 2005, Kamwendo et al., 2000). Participants in the present study perceived that developing personal resilience and healthy coping mechanisms during education should be core targets of nurse education and not seen as *'the icing on the cake'* (FG4). In line with this, lecturer participants considered it necessary to support students in developing personal resilience by learning about self and self-healing: *"sorting out your own mental health"* (FG5) in order to be a healthy role model. Participants in the present study also perceived being innovative, creative and flexible to be necessary defining attributes of healthy role models (Section 5.9.3), which was not previously identified in the literature.

Student nurses, RNs and educators were all concerned that the requirement for nurses to be role models in health promoting behaviour might have a negative impact on nurse recruitment (Section 5.5.2). All discussions surrounding recruitment inferred the requirement to be healthy role models is not currently being met. Lecturers were concerned that selection bias would involve negative decisions against overweight applicants at interview. Student nurses argued *“you will get even less people coming into the profession”* (FG1) because of the pressure to adopt healthy lifestyles. Not all participants thought the requirement would have a negative impact and listed positive impacts such as improving health and quality of life for some people, and improving their own health and well-being (Section 5.5.1), even if the impact on society to result from role modelling to be minimal.

6.3 Relevance of the concept

Information on the relevance of the concept was extracted from nursing literature and qualitative data. Many participants in the present study considered it relevant to their role to be a healthy role model despite being unaware of the NMC statutory requirement. Furthermore, some considered it an obligation. Many perceived that as healthy role models they could bring about behaviour change in others and have an effect on the wider community of friends, colleagues and family (Section 5.8.3). Participants considered that as healthy role models they could have an impact on public health, contribute to addressing the current obesity epidemic and considered they could have an impact on the health of the nation (Section 5.5.1). This supports perceptions in nursing literature that nurses as healthy role models could be seen as leaders and champions in public health (Dobinson-Harrington and Cornforth, 2006), bring about behaviour change in others, reduce population risk factors and have a positive influence on the health of the public (Roux et al., 2014, Moxham et al., 2013, Merrill et al., 2010, Shriver and Scott-Stiles, 2000, Dalton and Swenson, 1986, Eggertson, 2013).

The relevance of nurses as healthy role models to organisations was suggested in the literature as potentially delivering high quality patient care (Blake and

Harrison, 2013) and government policy (Blake et al., 2011, Malik et al., 2011). Qualitative data supported the literature and added further definition; many perceived *features of being a healthy role model* (Section 5.9) considered by participants in the present study could be argued as indicative of high quality patient care. One RN (FG6) stated that “*improved patient outcomes*” were a direct consequence of nurses being healthy role models. One group of lecturers (FG4) considered nurses should be politically aware, however felt suspicious that they would become “*agents of the state*” by being role models. Suspicious or not, such views suggest that delivering government policy was considered relevant to being a healthy role model. It was suggested in the literature that a nurses as healthy role models validate and add credibility of advice being given to patients so they are more likely to heed advice (Dunkley and Ward, 2005, Ball, 1997, Holt, 2008, Blake and Harrison, 2013, Blake and Patterson, 2015), and educating students to become healthy role models could provide organisations with a new generation of public health workforce (Blake and Harrison, 2013). Most participants in the present study considered being healthy themselves encouraged others to heed advice they provided (Section 5.5.1).

There is a lack of evidence about measured outcomes of nurses as role models in health promoting behaviour in the literature, however perceived outcomes of the concept were identifiable and further supported by qualitative data in the present study. Perceived outcomes or consequences identified in nursing literature suggested that nurses consider being healthy role models could help improve their personal health by helping them cope with stress (Malik et al., 2011, Shriver and Scott-Stiles, 2000). Participants in the present study also considered being a healthy role model involved improving personal health, and discussed the need for personal resilience and valuing self to cope with stress, albeit while often recognising barriers to doing so because *working as a nurse does not always support own health*. In contrast some participants considered meeting the requirement to be role models in health promoting behaviour added pressure and stress to their role; which supports previously identified considerations of Rush et al., (2005), Blake and Patterson, (2015) and Pollard (2005). Overall qualitative data from the present study supported the literature

that many nurses consider being healthy role models relevant and important to their role, albeit that some find it a pressure, which they consider unfair or an added burden. However, one RN in the present study provided a perspective which was not considered in the literature: she considered being a healthy role model in acute settings not as relevant, considering it low priority and the “*last thing on my mind*.” It is therefore not possible to identify how many nurses working in acute or critical care settings share this view, but it raises the question of whether consideration should be given to the relevance of healthy role models in certain critical care settings.

6.4 Selection of the concept

Schwartz-Barcott and Kim (2000) recommend that during the final analytical phase the researcher re-examines the findings in view of the initial focus of interest to consider if the selection of the concept seems justified. The concept of nurses as role models in health promoting behaviour was selected due to the author's personal experience of perceived incongruence between the lifestyle behaviours of nurses and what was taught in the classroom. Informal exploration of the topic whilst teaching registered and post-graduate nurses identified mixed opinions amongst nurses about whether the requirement to be role models in health promoting behaviour. Justification for selection of the concept went beyond personal interest of the author: evidence of mixed opinions of nurses in the literature towards being healthy role models appeared to conflict with an existing NMC statutory requirement (Section 2.5). Participants in the present study also presented a divide in opinions surrounding the requirement to be healthy role models (Section 5.5).

Critical review of literature in Chapter 2 identified a gap in knowledge in how UK nurses define the concept of role modelling health promoting behaviour and a greater understanding of health promotion was considered necessary for nurses to be healthy role models (Section 4.3.2). Most participants in the present study highlighted that they were unaware of the NMC requirement (5.6.1) and also found it difficult to understand the concept. It could help student nurses to meet the statutory requirement to become role models in health

promoting behaviour if they were provided with detail of what it involves. Defining attributes identified in both nursing literature (N) and qualitative data (Q) combined in this Section outline clusters of attributes, which could provide such detail (Table 6.1). Nine defining attributes were identified in nursing literature (Table 4.2) and organised within two categories: individual qualities (being caring, non-judgemental, trustworthy, inspiring, self-aware and self-caring) and societal qualities (portraying self as a nurse in a healthy way, being an exemplar and championing health and wellness). Qualitative data from this study corroborated the defining attributes from the literature and added further definition. The theme 'features of being a role model' (Section 5.9) was particularly relevant to identifying defining attributes. For example, being motivational, positive, charismatic and passionate can be linked to being inspirational. Being motivational was also identified as a key attribute in the cross discipline literature (C). Further defining attributes identified in cross discipline literature included behaving professionally and transmitting ethics, which are integrated in Table 6.1. Discussions about personal resilience in focus groups provided further understanding to 'being self-caring', previously identified in nursing literature. Participants considered being realistic a necessary quality; associated with being non-judgemental, also identified in nursing literature. Participants perceived being knowledgeable and self-confident as necessary personal characteristics for healthy role models however considered lack of knowledge surrounding health promotion often caused lack of confidence in nurses. Participants also perceived being innovative, creative and flexible as attributes of role models in health promoting behaviour and made many references to being professional, which was considered necessary.

Literature provided evidence that nurses, as role models in health promoting behaviour, are expected to portray themselves in a healthy way within society (Section 4.3.1) by not engaging in certain behaviours such as smoking (Chalmers et al., 2003). Participants confirmed this belief (Section 5.9.1) and added detail; they considered smoking, obesity and alcohol consumption not to be good role modelling. Participants considered projecting a healthy image by being fit and healthy as important to the image of nursing and to being a good

role model (Section 5.4.1). This was linked to being an exemplar in society as a defining attribute; many discussions about the necessity to 'practise what you preach' took place. Championing health and wellness; identified in nursing literature as an attribute of being a healthy role model was brought to life by participants describing advocates or catalysts for change to improve people's health (Section 5.9.3). The detail of perceived attributes presented in this Section, resulted from combining analysis of literature with qualitative data and provides information for nurses to meet a statutory requirement, thus justifying selection of the concept.

6.5 Presence and frequency of the concept in nursing

Both theoretical and empirical analyses in this study support the presence of an expectation for nurses to be role models in health promoting behaviour. Many participants considered role modelling important to their role, perceived that most nurses are, or aspire to be healthy role models (Section 5.5.1), however many struggled to describe 'real life' good role models and found it easier to recall poor examples. Nursing literature predominantly focused on lifestyle behaviours such as smoking, nutritional diet or exercise, and implied that a nurse as a healthy role model is not always a frequent occurrence. Both the empirical and theoretical analyses identified that for nurses to be healthy role models certain instances (antecedents) need to be in place, which are now presented.

Eleven antecedents of nurses being role models in health promoting behaviour were identified in the nursing literature (Table 4.3) which were grouped into four categories: individual (belief that being a role model can have an impact and valuing self), societal (social and political activism, obligation, belief that nurses are knowledgeable and image), organisational (workplace support, addressing factors which cause unhealthy coping mechanisms and nurses leaders to be healthy role models) and educational (understanding and application of health promotion in undergraduate and RNs). Qualitative data confirmed and further refined all antecedents identified in nursing literature. For example 'valuing self' was identified in the literature (Denehy, 2003, Denehy, 2008, Rush et al., 2005,

Rush et al., 2010) and participants in the present study discussed nurses not looking after themselves, often putting themselves last, considered a barrier to being a healthy role model; the need to 'give in' rather than always 'giving out' was suggested (Section 5.4.5). For nurses to be healthy role models it was suggested that a nurse has to believe they can have an impact on the health of others (Esposito and Fitzpatrick, 2011, Dao Thi Minh et al., 2008). Whilst participants in this study believed that being healthy role models could have influence on others (Section 5.8.3) some participants believed that patients in their care do not care how nurses behave and perceived many complexities such as family influence surrounding behaviour change as influential (Section 5.8). Antecedents identified within qualitative data, not previously identified in nursing literature have been presented in this chapter (Section 6.2)

Research suggests that for nurses to be healthy role models, students and RNs require wider understanding of health promotion (Holt and Warne, 2007, Blake and Chambers, 2011) and participants in the present study demonstrated lack of knowledge and understanding about the meaning of the term role model and health promotion (Section 5.6.1). Furthermore, participants claimed that they required a clear definition of role modelling health-promoting behaviour.

In summary the combination of theoretical and qualitative analyses in this section added weight to arguments made within non scholarly articles (opinion pieces and editorials) to suggest that some, but not all nurses are role models in health promoting behaviour.

6.6 Selection of Cases

Chapter 3 explained the purpose of searching for and identifying model, borderline, related and contrary cases. A large number of cases were not necessary within this hybrid model of concept development (Schwartz-Barcott and Kim, 2000). However direct quotes from qualitative data provided a brief case example of each. The following case examples explicate the essential elements of the nurse as a role model in health promoting behaviour.

Model Case

Wilson (1963) considered that a model case should make the analyst think: “well if that isn’t an example of it, then nothing is”. Participants were asked if they could provide an example of a real life, good role model. Most struggled, however one registered midwife (regulated by the NMC and bound by the same code of conduct) provided an exemplar case:

(FG6) “A midwife specialist in our place who looks after women with diabetes and she herself doesn’t have diabetes but she promotes a healthy lifestyle. She does health and fitness for us as midwives outside of work as a means of helping us promoting healthy lifestyles. I think it just ties in with her role as a diabetic specialist, she’s not saying to the women oh you shouldn’t do this, you shouldn’t do that, but she herself is immaculate, she is about 60 and there isn’t an ounce of fat on her, it does make us feel very ashamed but she doesn’t do it in that sort of way, she just presents it in a very gentle, sensitive manner and I think her way of helping us as a community if you like is by giving free aerobics sessions twice a week.”

The colleague was being caring, sensitive and portraying herself in a healthy way. She was inspiring and motivating others and appeared non-judgmental. She was taking care of herself, being an exemplar and championing health and wellness within her community. This model case includes all defining attributes of being a role model in health promoting behaviour set out in Table 6.1.

Contrary Case

A contrary case is a clear example of “not the concept”. Participant’s found it easier to explain what they considered ‘not’ a good role model than a good one. Qualities within contrary cases can be eliminated from the attributes of a concept and therefore reinforce defining attributes. A student nurse shared an experience of a contrary case:

(FG1) “In ITU one particular nurse was very addicted and would go out and smoke and come back with his scrubs stinking and I personally thought that was really unacceptable, I mean I can understand that he has an addiction but you’re wearing scrubs and

you're coming into that environment and your stinking of it and you know the patient's relatives would smell it"

Borderline Case

A borderline case is an instance of a concept, which contains some but not all defining attributes, which can often provide clarification that the model case is consistent with the concept. Identifying a borderline case can often make things even clearer (Walker and Avant, 2014). Participants were asked if they had experience of individuals 'partly' being role models. They struggled to provide an example of a borderline case however considered it to be associated with being inconsistent:

(FG6) "I think [you can be] partly [a role model] because you know what is expected but not actually behaving like you should be but also I think that is down to choice and perhaps maybe your personal character coming into that. They know what is right but they choose not to behave that way for whatever reason that might be...or whenever they are having a good day they will revert to what they know is right so it's the being consistently inconsistent. That's confusing, I get that, but some days, you can do what is right in role modelling but some days for whatever reason that might be you're not going to do it right. So yes you can be consistently inconsistent or you can have a consistent role model"

Related Case

The related case of the imperfect role model was identified as being related to but inconsistent with the general consensus of role modelling within the literature (Section 4.3.4). To recap, Rush et al (2005, 2010) argued the imperfect or humanised role model as better able to empathise with patients by sharing similar problems and lifestyle struggles. Some participants in the qualitative phase of this study perceived they were more able to empathise with people if they shared similar struggles; arguing the image of the perfect nurse was not useful (Section 5.7). However, participants' views were divided and the

majority considered sharing unhealthy lifestyle behaviours a barrier to being a good role model.

6.7. Empirical Referents

Defining empirical referents, the final step in concept analysis, provides a way to measure or demonstrate the occurrence of a concept, which is fully explained in Section 3.3. Empirical referents “are not tools to measure the concept” (Walker and Avant 2014: 174) but can be used to define the theoretical base of a concept to guide development of a tool (e.g questionnaire). Walker and Avant (2014) use an example of ‘kissing’ as an empirical referent to the concept of ‘affection’ to aide researchers understanding. Empirical referents (Table 6.2) add to understanding of defining attributes and were identified by re-examining the integration of the nursing literature and qualitative data.

Table 6.2: Empirical referents

Defining Attribute	Empirical Referent
Portraying yourself in a healthy way	Being fit and healthy by demonstrating healthy behaviours in some way and not being observed engaging in unhealthy behaviours e.g. smoking and eating fast foods
Being an exemplar, practising what you preach	Transferring knowledge of health behaviours to oneself, for one’s own wellbeing.
Championing health and wellness	Promoting healthy behaviours amongst colleagues, patients and wider community of family and friends

There are no tools designed to specifically measure nurses as role models in health promoting behaviour. Rush et al (2010) developed a self-rating questionnaire (SARMEP) to measure nurses’ perceptions of themselves as role models from the perspective of the imperfect role model, which included broad dimensions of the related case. For example, questions included: “I feel guilty when others see I am not practicing what I preach”, I accept that my personal health practices are less than perfect” and “health promoter describes better

what I do that role model”. The SARMEP tool as a whole is therefore not helpful to measure the concept of nurses as healthy role models but it may have some potential to be used in parts.

6.8 Summary

This chapter presented synthesised findings from the theoretical and fieldwork phases of this study. Overall the theoretical and qualitative data suggest that the expectation to be a healthy role model is generally perceived to be positive and relevant to nurses. However, some consider it an unnecessary additional pressure, which adds burden to an already stressed profession, which may have a negative impact on recruitment of nurses into the profession. Qualitative findings from this doctoral study demonstrated that many participants were unaware of NMC requirement to be role models in health promoting behaviour and considered a clear definition was required, which this study aims to provide. Findings provided clarity to the meaning of nurses as role models in health promoting behaviour (Table 6.1) far beyond the fragmented dictionary definition considered in Chapter 1: *‘to provide an example of personal actions to sustain or increase wellness serving as a model for others to emulate’*. To be healthy role models nurses need do much more than provide an example of personal actions. They need to be: caring (Hicks et al 2008, Brown and Thompson 2007, Blake and Harrison 2013), non-judgemental (Hagglund, 2009, Rush et al., 2010, Kinney and Erickson, 1990, Rush et al., 2005b), trustworthy (Marchiondo, 2014, Rush et al., 2005, Rush et al., 2010, Clarke, 1991, Glugover, 1987), inspiring and motivating (Rush 2000b), have a deep sense of self (Clarke, 1991, Rush et al., 2005b, Borchardt, 2000), be self-caring (Roux et al., 2014, Blake et al., 2011, Rush et al., 2010, Denehy, 2008, Hicks et al., 2008, Connolly et al., 2013, Connolly et al., 1997, Blake and Patterson, 2015), knowledgeable and self-confident, innovative and professional. By portraying themselves in a healthy way (being fit and healthy), being exemplars and championing health and wellness nurses can improve personal health and cope better with the stress of the job. Separating out and identifying the imperfect role model as a related case aided theoretical clarification of the concept and raised further

questions for consideration when analysing attitudes of nurses, which are discussed in Chapter 7.

Chapter 7: Discussions and conclusion

7.1 Introduction

In this chapter key findings are summarised, interpreted and discussed which answer the research questions:

- What does the term role modelling in health promoting behaviour currently mean to the nursing profession?
- What are nurses' attitudes towards role modelling health promoting behaviour in the context of the requirement for student nurses to become role models in health promoting behaviour?

The broad aims of the study to promote theoretical clarity of the concept and to investigate student nurses, nurse educators and RNs' experiences and perceptions of role modelling health-promoting behaviour were addressed by:

- Identifying antecedents, defining attributes and consequences of the concept within literature (theoretical phase) qualitative data and integrating both (final analytical phase), thus adding to existing literature.
- Exploring opinions, values and beliefs surrounding the concept with student nurses, RNs and nurse educators (fieldwork phase).
- Exploring experiences in practice: what is observed of RNs encouraging health-promoting behaviour through role modelling (fieldwork phase).
- Exploring whether student nurses, RNs and nurse educators perceive that the educational experience prepares students to meet the requirement to role-model health promoting behaviour as RNs and whether any improvements could be made (fieldwork phase).
- Exploring factors which student nurses, RNs and nurse educators perceive to affect their ability or desire to act as role models in health promoting behaviour (fieldwork phase).

The findings presented in the previous chapters will be discussed in relation to:

i) the theoretical clarity of the concept, ii) nurses' attitudes to being healthy role

models, iii) preparing student nurses to become role models, and iv) organisational understanding of complexities to support nurses as healthy role models. These discussions provide implications and recommendations for nursing, nurse education, organisations, policy and the wider public health agenda. Final consideration is given to the strengths and limitations of the study and further research.

7.2 Theoretical clarity of role modelling in health promoting behaviour

Concept analysis can help clarify terms that have become a catch phrase but lack clear definition (Walker and & Avant, 1983). As the term 'role model' has previously been used in the context of health promoting behaviour among health professionals without clarification, a concept analysis was considered an important and useful process to enhance understanding of what is being asked and expected of nursing professionals (DH, 2009, DH, 2010, DH, 2011, NMC, 2015, ICN, 2010). Chapter 1 presented a gap in knowledge of how UK nurses define the concept of being role models in health promoting behaviour, as dictionary definitions provide only a fragmented definition of the concept; it was therefore discerned as timely to provide deeper understanding and to explore nurses' attitudes to being healthy role models. Participants in this study also confirmed the need for further clarification (Section 5.6.1). A social constructivist stance, which underpinned the design of this study, provided a critical approach of a taken-for-granted professional requirement; taking into account nurses' values, beliefs, backgrounds and roles in society in an ever-changing healthcare environment. The methodological framework of a hybrid concept analysis and development approach proved effective by facilitating triangulation between literature (N,C) and qualitative analyses (Q) to define attributes, antecedents and consequences of nurses as role models in health promoting behaviour (Table 6.1). This process, which is outlined in Chapter 6 provided clarity beyond the limited meaning found in literature; a definition summarising the findings of the three phases of this thesis is presented in Figure 7.1

Figure 7.1 Definition of a role model in health promoting behaviour

Being a role model in health promoting behaviour involves being an exemplar, portraying a healthy image (being fit and healthy), and championing health and wellness. Personal attributes of a role model in health promoting behaviour include being: caring, non-judgemental, trustworthy, inspiring and motivating, self-caring, knowledgeable and self-confident, innovative, professional and having a deep sense of self.

7.3 Nurses' attitudes to being healthy role models

Being an exemplar, portraying yourself in a healthy way or being a champion of health and wellness within society are affiliated with being a healthy role model (Blake and Chambers, 2011, Jaarsma et al., 2004, DeMello et al., 1989, Chalmers et al., 2003, Blake and Patterson, 2015, Malik et al., 2011). However, there are opposing views within the profession about the requirement to be healthy role models, evident in literature and in participants of the present study (Section 5.5). Most participants in this study believed they had an obligation to be, or should aspire to be healthy role models, considering it important to their role. They considered that the health promoting advice they provide has more impact if they '*practise what they preach*' which supports arguments presented in nursing literature (Blake and Patterson, 2015, Esposito and Fitzpatrick, 2011, Hicks et al., 2008). In contrast a few participants were critical of the requirement to be healthy role models. They considered being healthy a matter of personal rather professional choice and argued that nurses should mirror society and struggle with the same problems; by being '*imperfect role models*' they were more empathetic with patients This view was consistent with the related case identified in the literature (Rush et al 2005b & 2010). However there is evidence that nurses' attitudes to being healthy role models is affected by their own

weight (Blake and Harrison, 2013) and smoking status (Slater et al., 2006). This raises the question of whether cognitive dissonance has a part to play in nurses' arguments for sharing similar health struggles as patients. This hypothesis was not investigated within the present study.

7.4 Preparing student nurses to be healthy role models

The need to improve the personal health of students during education is important to prepare them for their role as RNs (Blake and Chambers, 2011, Blake and Harrison, 2013, Yeh et al., 2005, Kamwendo et al., 2000, Darch, 2014). Unhealthy coping mechanisms identified in this research were often attributed to the pressure and stresses of the job and included comfort eating, smoking and alcohol consumption. Nurse lecturers considered developing personal resilience and self-care essential during nurse education to encourage healthy coping mechanisms. Both lecturers and RNs described the '*sort of people*' attracted to become nurses as often carrying '*baggage*' who are often not good at putting themselves first. This view was not directly evident in the literature retrieved for this study, although the concept of nurses as '*wounded healers*' and the suggestion that self-healing may be required for some before they can heal others has been previously recognised in a nursing text *The Nurse as Wounded Healer* (Conti-O'Hare, 2002). The term '*wounded healer*' was first used in reference to psychotherapists feeling compelled to treat patients because they, themselves were wounded (Jung, 1951). There is no evidence to suggest that nurses do approach the profession from the perspective of the *wounded healer*. Nonetheless, this may suggest that there is a need to explore whether self-healing is required during education for those preparing to become nurses. A feminist perspective which includes equality in respect for others and for self (Bent, 1993) from the outset could support both male and female student nurses to become healthy role models, through developing personal resilience and healthy coping mechanisms.

In Section 5.6.1 the ongoing confusion (Holt and Warne, 2007) and lack of understanding surrounding health promotion within the nursing profession was highlighted. Lecturers suggested integrating health promotion into all aspects of the curriculum rather than teaching it in isolation. There is currently

inconsistency across universities in how public health and health promotion is taught; some include a compulsory element while some offer it as an optional module. If nurses are required to be role models in health promoting behaviours post-registration, it is suggested that education should prepare them to be competent in doing so. Encouraging students to transfer knowledge gained about health during education to personal behaviours could support students to become healthy role models (Holt and Warne, 2007, Blake et al., 2011). University curricula are carefully monitored by the NMC to ensure clinical competency of RNs in caring for people when ill, however if competency encompassed an increased focus on positive health and wellbeing, it could provide greater understanding and knowledge of health promotion. Students, lecturers and RNs in this study considered there to be a theory-practice gap (Section 5.6.2) surrounding promoting health and advocated a more experiential approach to education such as becoming engaged in environmental and self-care activities which could help address the gap. Furthermore, if, as lecturer participants suggested, students felt empowered to challenge workplaces it could also aide transferring learning into clinical placements.

7.5 Organisational understanding of complexities to support nurses to be healthy role models

If organisations understood complexities such as the possibility that some nurses enter the profession with unhealthy coping mechanisms (Section 5.3.1), often the result of work pressure (Timmins et al. 2011; Beletsioti-Stika and Scriven, 2006), it is suggested that they would be better able to support nurses to be healthy role models. Speaking at the last NHS Innovations conference, Simon Stevens announced NHS employers should boost staff health with six key actions: providing health checks for staff over 40, availability of therapies such as talking therapies, weight management and smoking cessation support, healthy food options, physical activity such as Zumba classes and competitive sport, and a specified board member to champion staff health and well-being (NHS, 2015). While a need for workplace health initiatives is supported by literature and qualitative data in this thesis, the organisational approaches listed

within the recommendations above are all individualistic measures that put responsibility for health improvement onto individual nurses, and lack a deeper understanding of the organisational determinants and potential for influence of nurses' health. The findings of this research suggest that nurses consider other workplace factors to be as or more important in determining their lifestyle behaviours than these; for example, requirements to work twelve-hour shifts, cultures which accept lack of toilet or refreshment breaks and lack of available drinking water. Such nurses might not be inspired to attend a Zumba class in the working environment. The inverse care law (Tudor Hart, 1971) should also be considered with such initiatives; those attending sporting activities will most probably be the more motivated and healthy individuals that need it least. It is advised that organisations might be better equipped to inspire individuals who are not active by understanding the complexity behind lack of motivation. If NHS reviews and ratings of organisations included the health and well-being of employees, this could be a measurable target for the board members who champion health for employees (NHS 2015).

Participants in this study considered workplace stress leads to unhealthy coping mechanisms in nurses (Section 5.3.2), thus supporting previous research (Denehy, 2008, Beletsioti-Stika and Scriven, 2006, Trossman, 2013). Addressing workplace stress, which often leads to unhealthy coping mechanisms could involve a proactive rather than reactive approach to health and wellbeing. For example; promoting a healthier working culture for nurses by involving them in the process to determine what is required in each specific organisation may be more helpful than providing exercise and smoking cessation classes, as one size does not fit all. Participants largely considered their work environments unhealthy and many felt their employers did not look after them; all these factors were considered barriers to being healthy role models. Some individuals may consider fitness classes and healthy food helpful (NHS 2015) and participants in this study considered increased workplace support for mental health, counselling and smoking cessation important, which was consistent with suggestions in nursing literature (Slater et al., 2006, Pollard, 2004, Baron-Epel et al., 2004, DeMello et al., 1989, Dalton and Swenson, 1986, Connolly et al., 2013). However, such individual interventions

might be considered by some to be only part of the solution, because they do not influence the environment itself. It is advised that providing initiatives alone is insufficient; and any that are available should be accessible for those working long shifts which participants in this study perceived as not always the case. Most participants considered the accepted culture of their working environment was to not take breaks (Section 5.3.2). In such a culture the provision of healthy food is not helpful and it is advised that organisations could take steps to ensure that taking breaks is the norm. Workload was often cited as the cause of insufficient breaks, however some nurses avoided breaks to shorten their working day for second jobs or family commitments, thus highlighting the pressure some nurses are under to juggle employment and personal commitments.

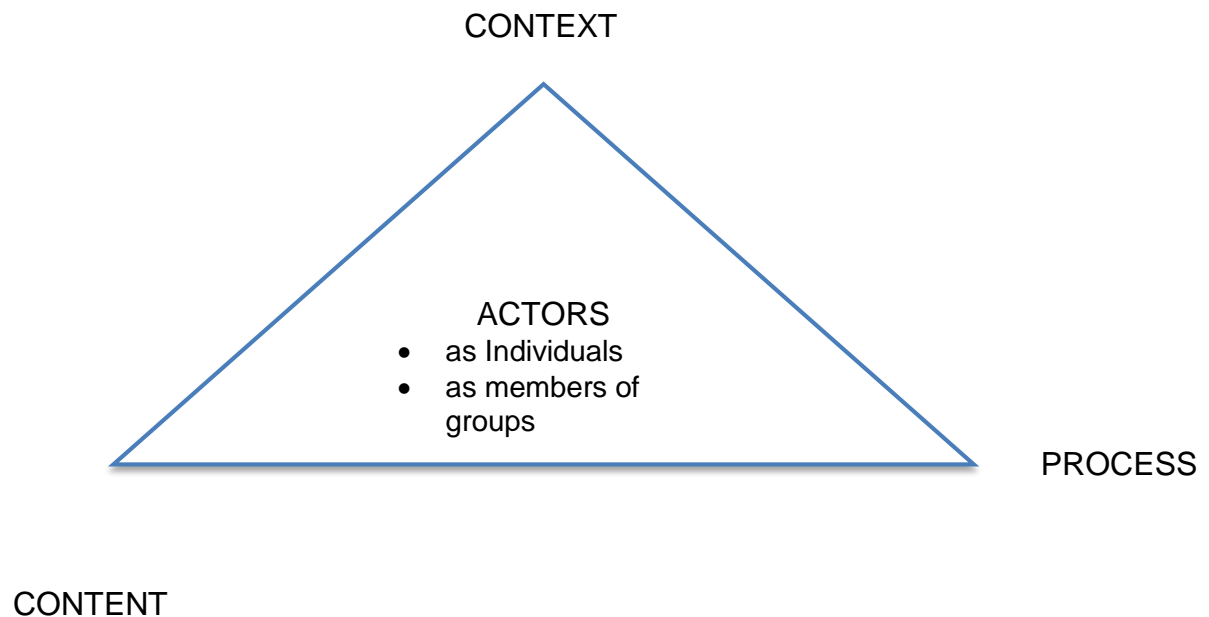
Participants considered themselves undervalued by the organisations in which they worked and felt they lacked a voice. They linked their personal health to their ability to be healthy role models (Section 5.3.2) consistent with a recent UK study (Johnston et al., 2016). In this study the authors examined physiological and psychological effects of task stressors and theory-based stressors (e.g control and reward) of 100 nurses working on medical and surgical NHS wards. They found increased perceived control over work resulted in lower stress, improved mood and decreased fatigue. Although the study tested correlation of constructs relating to stress rather than causal relationships, the breadth of tests (heart rate monitoring, 12 item mood scale, work related stress questionnaires, work observation method by activity timing [WOMBAT], and ecological momentary assessment [EMA] diaries) contributed to rigour. This would support claims from RNs in the present study who perceived feeling undervalued by organisations and lack of control to influence change as barriers to becoming healthy role models. It is therefore suggested that the impact of nurses feeling undervalued and unable to influence change is considered by organisations. It is suggested that understanding is sought in the context of considered positions of professional power within a hierarchical organisation; despite claims that medical dominance is in decline (Harrison and Ahmad, 2000) participants in this study considered themselves not as highly regarded as doctors by society.

7.6 Wider implications of research findings for policy and the public health agenda

Policy

Although most nurses consider they have a role to play in society as health promoting role models (Warren et al., 2008) some participants in the present study were suspicious and angry about the motives behind the requirement to be healthy role models. They considered it to be working to a government agenda, making them '*agents of the state*'. Some believed the government did not care about the health of nurses other than for the impact it could have on others. The authors of two UK papers (Blake et al., 2011, Malik et al., 2011) considered nurses and NHS staff acting as role models for healthy living is "imperative" to the delivery of UK government health policy. The authors further suggested that nurses meeting government requirements to be healthy role models reduce sickness absence, considered a preventable financial burden. However they do suggest that supporting nurses to become healthy role models through education may also help them as individuals by helping them cope with the stress of the profession (Malik et al., 2011). Suspicions of government policies which include nurses to be healthy role models could be reduced if the government presented such policies with consideration to factors that may affect successful implementation. The Walt and Gibson (1994) health policy triangle provides a systematic way to analyse the success of health policy implementation and presents a relevant framework. Walt and Gibson (1994) argue that too much attention is given to 'what' health policies are rather than 'how' they should be carried out or 'who' might resist them, suggesting that actors, context, content and process (Figure 7.1) should be considered when implementing policy. *Actors* refers to individuals, organisations or the state that affect policy. *Context* refers to political, economic, social or cultural factors. *Content* is the substance of a policy and *Process*; the way in which the policy is initiated, implemented and evaluated (Walt and Gilson, 1994).

Figure 7.2: Walt and Gibson policy analysis triangle



The concept analysis approach used in this study provided clarity to the *content* of nurses as role models in health promoting behaviour (Section 5.9); that is, what nurses are required to do as healthy role models. As previously discussed in Section 5.5.2 some participants considered it unfair to be told how to live their lives which suggests that involving them in policy decision-making processes could promote ownership by not neglecting the actors (Walt and Gilson, 1994). Examples of context (political, economic, social or cultural), which could be provided in policies recommending nurses as healthy role models, are:

- Contribution to halting the tide of chronic disease (ICN 2010)
- Perceptions of a nurses' role within society: participants in this study considered that not all patients required nurses to be role models (Section 5.4)
- Diversity in cultural attitudes health (Section 5.8.2)

If policies which include the expectation of potential behaviour change of nurses (Dao Thi Minh et al., 2008, Halcomb, 2005), included the process of how nurses will be supported to meet that expectation, then it would demonstrate understanding of what needs to be in place for change to occur. In turn

demonstration of understanding might address concerns of nurses (FG4) that “*government is focusing on it in the wrong way*”. The qualitative and theoretical findings discussed in Section 6.4 identified that for nurses to be healthy role models certain instances (antecedents) need to be in place: it is suggested that such instances become part of the process. Evidence of efficacy of nurses as healthy role models is limited and policy makers could consider how to evaluate a policy, which includes such content. These considerations may not be the whole solution but may be a step forward.

Wider public health agenda

Public health and health promotion has been discussed as integral to a nurse’s role (Section 2.3) and advocated within UK health policy over three decades (Holt and Warne, 2007). Chapter 6 identified perceived consequences of nurses as healthy role models (Section 6.2) from literature and qualitative data relevant to the wider public health agenda, for example reducing population risk factors and having a positive influence on health of public, thus improving the health of the nation. Furthermore the expectation to be role models can have a positive impact on the personal health of nurses (Malik et al., 2011, Shriver and Scott-Stiles, 2000). However, many participants in this study considered that working as a nurse does not always support them in being healthy (Section 5.3). It is suggested that the working life of a nurse is pertinent to the wider public agenda.

7.7 Strengths and limitations of the study

This study provides more clarity of meaning to the concept of nurses as role models in health promoting behaviour than was evident in the literature. However, limiting factors should be acknowledged. Qualitative data were collected in one area of England and this should be considered when applying findings in other countries or other areas. However, integration of international literature contributed to an international perspective. There is always a risk with focus groups that participants respond in a way that would please other members of the group and forceful members dominate discussions (Kitzinger,

1994). Qualitative findings from this study highlighted differing opinions on the subject within each group, which suggests that participants were open enough to voice their opinions. It was beyond the scope of this study to establish the associations between health behaviours of participants and the divided attitudes towards being role models for health promoting behaviour, which would be valuable to consider in a future study. To meet the broad aims of the present study to investigate student nurses, nurse educators and registered nurses' experiences and perceptions of role modelling health-promoting behaviour, data from all focus groups were analysed together. Some recognition should be given that opinions and experience within these groups could vary significantly, and might have benefited from individual grouping. However, all groups provided data with common themes which was identified in Chapter Five. Whilst nurse educators and students contributed most notably to discussions surrounding undergraduate education, no significant discrepancy was detected between the two groups.

This study adapted a hybrid approach to concept analysis, which those who favour a pure approach might consider a compromise. However, the appraisal of approaches presented in Chapter 3 resulted in an adapted framework, which proved effective in answering the research questions for this study and provided triangulation between literature and qualitative analysis. Rodgers evolutionary approach recommended greater emphasis on retrieval and analysis of multi-disciplinary literature, which this study did not favour. Findings from the multi-disciplinary literature in this study provided a platform from which to commence analysis but the greatest insight was achieved by nursing literature and qualitative data. The quality of any literature analysis relies on the quality of the material retrieved and this study included some non-scholarly articles to capture current understanding of the concept in the popular nursing press. Nonetheless nursing literature included 38 research studies and 15 scholarly articles which outweighed the unreferenced ($n=6$) articles or opinion pieces ($n=18$).

One final consideration should be given to the professional role of the researcher as a registered nurse and nurse educator. The researcher,

professional and academic supervisors took every opportunity to minimise personal biases, however previous experience and interest in the concept could not be removed.

7.8 Summary of recommendations

Recommendations, which can be drawn from this chapter, are illustrated in Table 7.1

Table 7.1 Summary of recommendations

<p>Education</p> <ol style="list-style-type: none"> 1. Inclusion of teaching strategies to support self-healing and personal resilience 2. Experiential teaching strategies to teach those who care for others to care for themselves 3. Integration of health promotion across entire curriculum 4. Empowerment of student nurses to challenge workplaces so they can transfer learning about health promotion into clinical environments 	<p>Policy and public health agenda</p> <ol style="list-style-type: none"> 1. Involve nurses in policy-making decisions that present expectations of potential behaviour change of nurses 2. Policies to provide context and process, rather than delivering content alone 3. Recognition of a link between the working life of a nurse and the wider public health agenda
<p>Organisations</p> <ol style="list-style-type: none"> 1. Addressing of workplace stress to involve a proactive rather than reactive approach 	<p>Nurses in practise</p> <ol style="list-style-type: none"> 1. Nurses could embrace healthy behaviour and transfer what is learnt about health to their own life

<p>2. Workplace health initiatives and support which considers the needs of those working shifts</p> <p>3. Organisational culture conducive to nurses well-being which includes listening to what nurses need in individual workplaces</p> <p>4. NHS reviews and ratings of organisations to include health and wellbeing of employees, the responsibility for which sits with a specified board member</p>	
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7.9 Recommendations for further research

Many participants in this study felt that being a healthy role model would encourage patients in their care to heed advice they give which is supported with limited literature (Blake and Patterson, 2015, Esposito and Fitzpatrick, 2011). The Populas poll (RSPH 2014) discussed in Section 2.4 suggested that respondents were 51% less likely to take advice on diet and exercise from an overweight nurse. However, 43% replied that it made no difference either way. It was unclear from the poll, what proportion of participants had previous healthcare experience; many may have had limited contact with nurses. A few participants in the present study considered being healthy role models of minimal consequence for a patient, which creates a tension between a NMC statutory requirement and nurses' perceptions. Evidence that patients in a NHS clinical environment feel they are more likely to heed advice from healthy role models would provide a stronger rationale for the continued inclusion of this requirement by the NMC. If role modelling is found to be important, further research to explore what patients consider the attributes of a nurse being a

healthy role model is warranted.

Rush et al (2005, 2010) argued that nurses could be role models for health by experiencing and sharing similar health problems with patients because it allows them to be empathetic and some participants in this study shared the view. Future studies could consider whether negative and positive attitudes to being a healthy role model are affected by personal factors such as weight (Blake and Harrison, 2013) and smoking (Slater et al., 2006). A mixed methods study to examine associations between attitudes and personal measurable factors (e.g weight, smoking, alcohol consumption) would test the suggested relevance of cognitive dissonance suggested by some (Blake and Patterson, 2015, Holt and Warne, 2007). Future studies should involve a cultural and ethnic mix of nurses to include cultural variance of attitudes to what is understood by healthy lifestyle.

7.10 Conclusion

The aim of this research was to promote clarity to the concept of nurses as role models in health promoting behaviour, and increase understanding about nurses' attitudes towards the NMC requirement for student nurses to become role models before registering as nurses. Throughout the research process, insight and greater understanding was gained of the complexities relevant to nurses being healthy role models from an individual, organisation, educational and societal perspective. For example, some nurses felt they required education regarding self-care and self-healing from the outset of education, felt undervalued by organisations and government, considered working environments unhealthy, and felt the profession was not well respected.

The study phases identified a national and international expectation for nurses to be healthy role models and demonstrated that the expectation is not consistent with the reality of nurses' health and health behaviours. Furthermore, a gap in knowledge of how UK nurses define the concept of being role models in health promoting behaviour was identified in the literature. This was also reflected in the qualitative work that found most participants in the present study were unaware of the NMC requirement to be role models in health promoting

behaviour and considered it difficult to understand what was meant by the concept. The insight into individual, organisational, societal and educational antecedents, attributes and consequences (Table 6.1) and the definition presented in this chapter (Figure 7.1) addresses a gap in knowledge for nurses to understand that being a healthy role model is more than just being fit and healthy. It is important that if the expectation for nurses to be role models in health promoting behaviour continues, evidence considered in this thesis suggests they should be supported from the outset of education to fulfil the role, be supported by organisations following registration and not neglected in relevant policy decisions. Nurses are best placed to inform organisations and policy makers of strategies to support them; they are the principal actors.

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Appendix 1: Focus group topic guide

Nurses as Role Models in health promoting behaviour: Concept Development and Analysis

Offering of Drinks and Refreshments

Welcome and thank you for volunteering. In total there will be a six focus groups conducted and at the end of this session you will be invited to enter a draw for a £100 Amazon voucher which will be drawn following the final focus group, date to be confirmed.

The aim of this focus group is to gain understanding of the use of the term role model as used by the NMC in the statutory requirement for registration that “All nurses must take every opportunity to encourage health promoting behaviour through education, role modelling and effective communication”.

The discussion should take approximately an hour but may go on a little longer

There are no right or wrong answers in this discussion, please feel free to disagree and offer alternative view points but do so in a respectful manner

Try to let one person talk at a time and do not talk over each other as I wish to hear everyone’s viewpoints for the sake of data collection

Please could you switch off your mobile phones for this short period of time?

You should all have had the opportunity to read the participant information sheet (PIS) and in a moment I will ask you to sign a participant consent form

So we are focusing on your views and opinions of nurses role modelling health promoting behaviour (Added after first focus group)

Questions

What do you think that means? (Added after first focus group)

1. Can you identify any experiences/examples of observing registered or student nurses role modelling to encourage health promoting behaviour?
2. Do you have any experiences of observing registered or student nurses not role modelling to encourage health promoting behaviour?
3. Can you identify characteristics or personal qualities, which could be associated with the concept of role modelling to encourage health promoting behaviour?

4. What are your views about the requirement for nurses to encourage health promoting behaviour through role modelling?
5. Do you believe that nurses' role model health-promoting behaviour could impact on lifestyle behaviours of others?
6. What do you think are the consequences/ impacts or potential consequences of nurses encouraging health promoting behaviour through role modelling?
7. Do you feel that nurses currently do role model health promoting behaviour?
8. What do you feel needs to be in place during nurse training for nurses to become effective role models in encouraging health promoting behaviour?
9. Can you identify any experiences/examples of observing registered or student nurses partly encouraging health promoting behaviour through role modelling?
10. Can you identify any factors that might affect the ability or desire for nurses to act as role models for health promoting behaviour?
11. Do you feel there is anyway in which the education of nurses could be improved to meet this requirement to encourage health promoting behaviour through role modelling?
12. Do you feel that your workplace supports nurses to become effective role models in encouraging health promoting behaviour?

Any other comments about the topic of role modelling to encourage health promoting behaviour?

Appendix 2 Participant Information Sheet

Thank you for considering taking part in a research study on Role Modelling in health promoting behaviour

We wish to recruit participants who are willing to take part in a focus group. The following information is to inform your decision to take part but if you have any questions please contact Joy Darch jld33@bath.ac.uk . Tel 07970011765 This project has been reviewed by and received ethics clearance through the Research Ethics Approval Committee for Health, University of Bath

What is the purpose of this research?

This research aims to investigate the concept of role modeling health promoting behaviour in the context of the Nursing and Midwifery Council's requirements for pre-registration education. The study will investigate student nurses', nurse educators and nurses' experiences and perceptions of role modeling health-promoting behaviour. The research will contribute to the researcher's thesis for a Professional Doctorate (Health) at University of Bath.

Who are the researchers?

The investigator and doctoral student is Joy Darch. Her supervisors are Professor Lesley Baillie (London South Bank University and clinical research Chair for the Florence Nightingale Foundation) and Dr Fiona Gillison (Senior Lecturer Psychology, University of Bath f.b.gillison@bath.ac.uk)

Joy Darch will facilitate the focus group.

What types of data are being collected?

Data are being collected from focus group discussions, which will be audio-recorded.

A focus group is a group discussion 'focused' on a topic or theme- on this occasion *role modelling in health promoting behaviour*. You will be expected to talk to each other and the facilitator and to indicate whether you agree or disagree with what is being discussed. We are interested in your opinions, views and experiences and would welcome a lively discussion. Remember there are no right or wrong points to be made or answers to any questions asked of you.

What will participating in the study involve?

The focus group will include the facilitator (moderator), and approximately 6-8 participants. It is planned that the discussion will last for 90 minutes.

You will be asked to talk about issues relating to nurses acting as role models in health promoting behaviour. Questions will relate to your views opinions and experience on the topic and will not focus on your own personal lifestyle. However if you wish to include any personal points in the discussion it is at your own discretion and you are more than welcome to do so.

What will happen?

Once everyone has arrived, each participant will be provided with a name badge to wear during the discussion; you can use a pseudonym if you so wish. You will be provided with a consent form to read and sign.

The facilitator will explain what is going to happen and you will be given the opportunity to ask any questions at that point.

Ground rules will be suggested for everyone to agree on before commencing (e.g. avoid all speaking at once, considering others feelings, how to indicate that you wish to add a point when someone is speaking etc).

Once everyone is happy to commence the recording device will be switched on and the facilitator will ask the first question.

You will be provided with a further opportunity at the end of the session to ask questions.

What are the benefits to participating?

Taking part will offer you the opportunity to engage in a discussion that you may find interesting.

Refreshments will be provided and should you wish, as a 'thank you' you will be entered into a draw for a £100 Amazon Voucher

Are there any risks involved?

There are no risks anticipated and all information has been provided honestly. A general risk of group discussions is that you could feel upset by a particular area being discussed or another participant's behaviour or comment. If you are a student, and feel upset about anything that has occurred in the focus group you are encouraged to approach your personal tutor for guidance and signposting to student counselling.

Will it be confidential?

Yes. All information provided by participants is anonymous and confidential. All participants will be asked to agree to refrain from discussing what other participants have contributed outside of the group or with other people.

The audio recording and the transcript from the focus group will be stored on a password-protected computer. The consent forms will be stored in a locked cupboard in accordance with the Data Protection Act

The transcript will be anonymised. Extracts from the transcript may be included within the findings section of the thesis and in publication but no individuals will be identifiable.

Can I withdraw from the research?

You are entitled to withdraw at any time during the focus group. In addition you can request that your data are withdrawn from the research at any time during the four weeks following the focus group. If you wish to withdraw please contact Joy Darch on the contact details provided above.

What if I have any concerns?

Should you feel that your interests are being ignored, neglected, or denied, you should inform the Director of Studies for the Professional Doctorate programme who will undertake to investigate the complaint. Director of Studies, University of Bath David Wainwright D.Wainwright@bath.ac.uk

What should I do next?

If you are willing to participate please contact Joy Darch jld33@bath.ac.uk. Tel 07970011765.

Appendix 3

Participant Consent Form - Focus Group on Role Modelling in health promoting behaviour

Please initial all the boxes provided and sign and date at the bottom

I give my consent to participate in the focus group on role modelling in health promoting behaviour.

☐

I have read the participant information sheet

☐

I understand that I am participating in the group in a voluntary capacity and am free to decline to answer any question or to leave the focus group at any time without providing a reason.

☐

I also understand that I can request that my data be withdrawn from the research at any time during the four weeks following the focus group.

☐

I understand that all information provided is anonymous and confidential and that I cannot reveal what is discussed by other participants of the group outside of the focus group.

☐

I understand that the focus group will be audio-recorded and transcribed by a professional transcriber. The recording will only be heard by the researcher team (Joy Darch and supervisors Professor Lesley Baillie and Dr Fiona Gillison) and the transcriber.

☐

I understand that the data will be analysed for the doctoral thesis of the researcher

☐

I understand that extracts and quotations from the transcript may be used in other presentations and publication but identity will be protected by the use of pseudonyms

☐

I understand that this project has been reviewed by, and received ethics clearance through, the Research Ethics Approval Committee for Health of the University of Bath



Name:

Signature:

Date:

Signature of Researcher:

If you have any further questions about this research study please contact Joy Darch jld33@bath.ac.uk . Tel 07970011765. or email Fiona Gillison F.B.Gillison@bath.ac.uk

Appendix 4

Participant Demographic Form - Focus Group on Role Modelling in health promoting behaviour.

In order to learn about the range of people taking part in this focus group, I'd be very grateful if you could provide the following information. All information will remain anonymous.

Please write your answer in the space provided or tick the box that best applies to you

1.	How old are you?			
2	I am:	Male	Female	Other
3.	How would you describe your racial/ethnic background? (e.g White; Black; White Jewish; Asian Muslim)			
4.	What is/was your parent's occupation?			
5.	What is your home post-code?			

Thank you

Appendix 5: Ethical approval

Department for
Health



UNIVERSITY OF
BATH

Bath BA2 7AY · United Kingdom

Telephone +44 (0)1225 383461
Email health@bath.ac.uk
www.bath.ac.uk/health

13th February 2015

Dear Joy,

Full title of study: Nurses as Role Models in health promoting behavior: Concept Development and Analysis

REACH reference number: EP 14/15 118

The Research Ethics Approval Committee for Health (REACH) reviewed the revisions to the above application at its meeting held on the 12th February 2015.

On behalf of the Committee, I am pleased to confirm that the Committee would be happy to provide a favourable ethical opinion of the above research, (on the basis described in the application form and supporting documentation).

Please inform REACH about any substantial amendments made to the study if they have ethical implications.

Kind regards

A handwritten signature in black ink, appearing to be 'Rachael Yates'.

Rachael Yates

Department Co-ordinator

Email: r.m.yates@bath.ac.uk

Tel: +44 (0)1225 383461

Appendix 6: Table of nursing literature

Web of Science

" Role model* "AND nurs* AND health* in topic

1986-2015

585 HITS

Excluded tributes and obituaries

Excluded those not relevant to role modelling health promoting behaviour

Total **57** retrieved

Citation	Summary notes	Instances	Defining Attributes	Antecedents	Consequences
(Marchiondo, 2014) USA	This SCHOLARLY ARTICLE defined the incidence of overweight and obesity in United States, including the nursing profession. It discussed strategies for addressing the obesity epidemic in the US, which included nurses acting as role models in healthy living. The author argues that nurses' perceptions of what constitutes a role model vary.	5	Acceptance, patience, encouragement and trust. Sharing of proven strategies Promoting healthy living through example	Education Worksite and community interventions Belief that self care to care for others is necessary.	Tackles obesity problem starting with themselves. More likely to teach 'healthful behaviour.'
(Sickora and Chase, 2014) USA	This SCHOLARLY ARTICLE used preliminary data to demonstrate how nurses can serve as role models to other disciplines in promoting health. Focusing on strategic partnerships in community in poor areas in US.	2	-	-	-
(Roux et al., 2014) USA	This article reported on a FEASIBILITY STUDY for the evaluation of a six-week nutrition and physical exercise intervention programme. The focus	9	Self caring -not being overweight	Workplace support for healthy lifestyle -supportive studying and working environment e.g	Behaviour change in others - positively impact a change in

	<p>of this article was obesity, which claimed that overweight and obese nurses may find it challenging to fulfill the expectation of healthy role models. The literature review of this paper lead to a discussion surrounding the prevalence of obesity in nursing which was considered as high as in the general population Roux argues that nursing curriculum is often lacking in advanced nutritional content. A control group was used. Authors stated that 31 students recruited but reports findings on 23 without explaining attrition. No significant change in post-test measurements. Authors made many recommendations and conclusions despite lack of evidence from study.</p>			<p>improved access to hot low calorific meals for shift work, increase in nutritional knowledge and taking an active role en determining what work and environmental situations are preventing them from reaching their goals and health status</p>	<p>their patient's behaviour</p>
<p>(Moxham et al., 2013) AUS</p>	<p>QUANTITATIVE STUDY used a descriptive survey design to determine smoking rates and attitudes towards helping patients to cease smoking. Student nurses and graduate nurses (<i>n</i>= 153) were reported to be aware that they are role models and that they had an influential role in modifying patient behaviour. Findings- younger nurses</p>	<p>12</p>	<p>Self care- by not smoking Smokers are discussed as 'poor role models'</p>	<p>Formal training on smoking cessation</p>	<p>Behaviour change in others- modifying patient behaviour.</p>

	<p>(18-27) had lower perceptions of smokers' rights and those that smoke themselves found it easier to develop a therapeutic relationship with a patient who is a smoker. However the concept of a therapeutic relationship is not discussed and whether being a role model is part of a therapeutic relationship. The authors suggested the nursing curriculum lacks content to prepare student nurses to provide adequate advice in smoking cessation. Authors claimed that this study provided evidence that there is a link between behaviours, attitude and beliefs of clinicians regarding smoking cessation and their duty as role models and agents of change towards their patients. One site study impacts on generalisability. Low Response Rate 26.1%</p>				
(Awopeju et al., 2013) Africa	<p>QUANTITATIVE STUDY used a cross sectional survey ($n=625$) to identify smoking prevalence and attitudes to smoking in university nursing, medical and pharmacology students. The smoking prevalence among health professional students in South- West Nigeria is relatively</p>	3	-	-	-

	<p>low; however, the majority believed that health- care providers serve as role models for their patients and the public. Three quarters believed that health professionals serve as role models.</p> <p>Sample size calculation is clearly stated.</p> <p>A standardised survey instrument was used.</p> <p>Validity- Findings are made from self reporting data which risks under reporting of smoking</p>				
(Blake and Harrison, 2013) U.K.	<p>This QUANTITATIVE STUDY investigated health behaviours in pre-registered nurses and their attitudes towards being role models to their patients. 540 pre-registered nurses self-reported their level of physical activity, smoking habits, alcohol intake and dietary habits. Overall, 24% were overweight or obese, 47% were not physically active enough to benefit their health, 73% did not eat the recommended five portions of fruit and vegetables per day, 40% reported binge drinking and 17% were smokers. Respondents commonly held the belief that nurses should be role models for health, although opinions</p>	28	<p>Empathy Self confidence (self aware) Ability to communicate (caring) Warmth (caring)</p>	<p>Positive image of nursing- not smoking in uniform and being a healthy weight, good health behaviours</p> <p>Understanding of health promotion in pre reg. nurses-Need to improve or reinforce nurse education regarding understanding of what constitutes a healthy and varied diet</p>	<p>Patients are more likely to heed advice on health behaviours</p> <p>High quality patient care</p> <p>Validates and gives credibility of advice (patients more likely to heed advice)</p>

	<p>varied according to the individual's own health profile.</p> <p>Data collected from one site only</p> <p>Validity- Findings are made from self-reporting data which mean that data may underestimated.</p>				
(Blake and Chambers, 2011) U.K	<p>This SCHOLARLY ARTICLE proposed that nurses are both targets and facilitators of health promotion. It further argued that nurses are ideally placed to be NHS <i>Health Champions</i> as they are viewed as role models by the general public despite evidence that they do not always heed their own advice.</p>	5	<p>Being an exemplar- 'Practise what they preach', and transfer their knowledge to their own health behaviours. Setting standards for health behaviours as early as possible in the nursing career.</p> <p>Championing health and wellness</p>	<p>1. Structured educational training in health improvement</p> <p>Understanding and application of health promotion in pre registered nurses</p>	<p>Supports the development of a 'new generation' of public health workforce.</p>
(Naish, 2012) U.K.	<p>This UNREFERENCED ARTICLE from a popular nursing journal reports on an MP who is calling for government action to tackle increasing levels of obesity among nurses. Naish argued that overweight and obese nurses need support from employers to make healthy food choices at work and become credible health educators and role models. It highlighted a divide between nurses that some feel that it is appropriate to have the same health issues as</p>	1	-	<p>Workplace support for healthy lifestyle- support from employers for healthy initiatives e.g healthy food in canteen which stays open for shift workers and keep fit clubs</p>	-

	others because it makes them more approachable v they feel that feel that they should practise what they preach.				
(Timmins et al., 2011) Ireland	<p>This QUANTITATIVE STUDY used a 146-item questionnaire adapted from the College Lifestyle and Attitudinal National survey ($n=246$) to identify lifestyle behaviours of nursing students. 36.6% were smokers. 11.4% reported having unprotected sex as a result of alcohol consumption. One third were stressed about finances. Stressors were associated with the last year of the programme and 10% reported taking drugs or alcohol to reduce stress. The authors argued that nursing students support the mental and physical health of others, and therefore in many ways ought to be a role model. Nurturing and supporting mental health is crucial to the future of profession.</p> <p>Reliability and validity testing of questionnaire is clearly identified and a pilot study was conducted prior to the study.</p> <p>Data obtained across two sites.</p>	2	-	<p>Understanding and application of health promotion in pre registered nurses-</p> <p>Support and encouragement of more healthy coping mechanisms by nurturing and support of mental health.</p>	-

	Reliability-Socially desirable responses may have been provided in the self-reporting questionnaire.				
(Blake et al., 2011) U.K	<p>This QUANTITATIVE STUDY uses a cross sectional questionnaire survey adapted from a national evaluation of UK workplace wellness programme which measures physical activity, general health, smoking behaviour, diet, alcohol behaviour and sickness absence. (n=325) This article provides evidence of the poor health profile of pre-registration nurses</p> <p>All years of study and all branches participated in the study but data is not provided to individual % of sample- difficult to establish any causability.</p> <p>Validity- self reported questionnaires.</p>	3	Self care by take responsibility for own health with optimal exercise habits, weight management and safe alcohol use	<p>Workplace support for healthy lifestyle. e.g Addressing of barriers to healthy behaviours e.g affordable and accessible tailored physical activity interventions for pre reg nursing population (walk or cycle to work initiative or interdepartmental sports tournaments) Available healthy food choices in the workplace.</p> <p>Education about role as exemplars of safe alcohol consumption</p> <p>Early education about the importance of maintaining and improving personal health, the financial impact of poor health on the NHS and the impact of poor health on their ability to effectively promote health to patients</p>	Successful delivery of government policy (UK)
(Esposito and	This QUANTITATIVE STUDY focused on the relationships between nurses'	3	Embracing of healthy behaviours	Belief in health promotion	-

Fitzpatrick, 2011) USA	<p>beliefs regarding the benefits of exercise, their exercise behaviour and their recommendation of exercise for health promotion. (n=112).Results: nurses who believe in health promotion and embrace healthy behaviours are more likely to be positive role models and teach healthy behaviours to their patients. Reliability of instruments are identified.</p> <p>Male sample size is low so results are not generalisable to male nurses in US.</p> <p>Data collected from one hospital in New York which may not be representative</p>				
(Rush et al., 2010) USA	<p>The aim of this QUANTITATIVE STUDY was to develop and test an instrument to measure nurses' perceptions of themselves as role models. Following the design of the SARMHEP (Self as Role Model for Health Promotion) instrument the tool was tested on participants. Factor analysis guided further development of the instrument. (n=115.) The authors discussed that extensive literature judges nurses as negative role models. <i>A strength of this paper lies in the critical review of the literature which challenged the</i></p>	100+	<p>Caring- warmth, empathy, listening</p> <p>Trustworthy and genuineness</p> <p>Non judgmental and accepting</p> <p>Self caring- watching weight and eating well and engaging in healthy lifestyle behaviours</p> <p>Inspirational and Motivational- Empowering</p>	<p>Belief that being a role model can have an impact</p> <p>Valuing Self</p> <p>Social and political activism</p> <p>An approach to health promotion that counters the traditional authoritative, prescriptive approach</p>	<p>Aggressive, condemning and arrogant attitudes and approaches to patients</p> <p>Helps consumers make health-promoting changes</p>

	<p>predominant understanding of role modeling health promotion. Small sample size for evaluating a newly designed tool.</p> <p>Although many attributes, antecedents and consequences are discussed many are relevant to the related case identified in this thesis</p>		Some perceive that personal behaviours such as smoking is helpful, rather than a discredit to them as role models.(the value of imperfection). Using flaws to motivate behaviour change in patients. <i>Humanised version- imperfection, equality and authenticity</i> behaviours effectively		
(Gainsbury, 2010) UK	This SHORT ARTICLE reported on a Nursing Times survey of 650 nurses. The author stated that results show NHS organisations are ignoring nurses' health and wellbeing by failing to provide proper breaks and neglecting those who work unsocial hours. Reference to role model is that 74% of nurses felt their director of nursing was not a good role model for a healthy life style	1	-	-	-
(Merrill et al., 2010) Serbia	This QUANTITATIVE STUDY assessed smoking prevalence, attitudes, and perceived patient counseling responsibilities among practicing nurses in Serbia (<i>n</i> = 230). Findings:	10	-	-	Behaviour change in others- assists patients to stop smoking

	<p>nurses who smoked were significantly less likely to believe that their counseling about smoking could be effective. They also felt significantly less well prepared to assist patients to quit smoking. 82% of nurses agreed that they should be role models for their patients and the public and 78% felt that they should set a good example by not smoking. Data collection multi-sites 99% response rate</p> <p>Validity- Unvalidated questionnaire but developed with reference to instrument used by WHO.</p>				
(Zapka et al., 2009) USA	<p>This QUANTITATIVE STUDY used anthropometric measurements and self-administered surveys to describe weight, weight related perceptions and lifestyle behaviours of nurses and explored the relationship of demographic, health, weight and job characteristics with lifestyle behaviours (<i>n=194</i>). Findings- Most nurses were overweight (37%) or obese (28%) and reported their work environment was stressful, average fruit and vegetable intake was lower than the recommended five a day and fat intake was higher than government</p>	6	-	<p>Workplace support for healthy lifestyle- A better understanding of nurses weight and work- Health care organisations being leaders in encouraging a systems approach to obesity prevention. E.g. healthy nutrition and physical activity newsletters/ posters emphasizing healthy choices and the role of nurse's as health role models, free snacks of seasonal fresh fruit and/or</p>	-

	<p>recommendations. Low physical activity levels were also highlighted. Multi-site data collection (6 hospitals) but in small geographical area-generalisability</p> <p>Self reporting- social desirability bias</p>			<p>whole grain products on the work units and reasonably priced to go box lunches/meals that can be delivered to busy work units. Onsite fitness centres that offer availability of equipment and classes before and after shifts, with adequate locker rooms.</p>	
<p>(Pericas et al., 2009) Spain</p>	<p>An observational cross sectional QUANTITATIVE STUDY (N=345) of nursing and physiotherapy students, which described perceptions, attitude and behaviour towards smoking. Findings demonstrate that non-smokers agreed that health professionals are role models more than smokers.</p> <p>Self reporting- social desirability bias</p> <p>Pilot study was conducted to validate questionnaire but only on 46 students.</p> <p>Data does not differentiate between physiotherapy and nursing student</p>	5	-	-	-

(Chambers and Thompson, 2009) U.K.	<p>The aim of this QUALITATIVE STUDY was to identify how nurses ($n=20$) use the concept of empowerment when engaging in health promotion activities in acute care settings. Findings identified two types of practitioner distinguished by how the conceptualise 'empowerment'. The authors suggested that nurses acting as role models are convergent rather than divergent thinkers.</p> <p>Very small scale study</p> <p>Does not take ask understanding of health promotion and assumes general understanding</p>	3	<p>Inspiring and motivating by empowering.</p> <p>Convergent thinking (this is argued to be a more biomedical approach to health promotion rather than a divergent thinker who bases strategies for patients on the relationship between health, illness, social structure and culture and is therefore more holistic</p>	-	-
(Warren et al., 2008)USA	<p>QUANTITATIVE STUDY. The Global Health Professions Student Survey (GHPSS) was conducted among third-year students attending dental, medical, nursing and pharmacy schools to examine tobacco use prevalence and tobacco cessation training among students. It was completed by at least one of the four target disciplines in 31 countries between 2005 and 2007 for a total of 80 survey sites. GHPSS data</p>	2	-	<p>Understanding of health promotion for registered nurses by providing training on counselling patients to quit using tobacco</p>	-

	demonstrated that the majority of health professional students recognised they are role models in society, believed that they should receive training on counselling patients to quit using tobacco, but in 73 of 80 sites less than 40% of the students reported they received such training				
(Denehy, 2008) USA	EDITORIAL. The author questioned whether school nurses are doing as much as they can to role model healthy weights and lifestyles to children	6	Valuing own personal health Self care -managing stress Setting an example as people who maintain normal weight. Acting on knowledge that is imparted to others	Value self	-
(Hicks et al., 2008) USA	This QUANTITATIVE STUDY used a visual analogue scale to provide some evidence that the visual appearance of nurses can have an effect on the general public's confidence in the profession. Two individual photographs of nurses were shown to participants; one was an average size ten/twelve while the second was a size twenty/twenty two (n=71). The aim was to evaluate	7	Caring – empathy, warmth Self care by 'being weight appropriate', practicing healthy habits, refraining from unhealthy habits Self-awareness respect, and	Nurse leaders that are positive and healthy role models to the rest of the nursing workforce Nurse leaders as healthy role models	The added burden of being a role model for patients will add to stress which is argued to already be related to some unhealthy behaviours

	<p>levels of confidence in the ability of overweight or normal weight nurses to provide health education in randomly selected members of the public. A significant difference in confidence $p=0.000$ was noted between participants who viewed the image of a weight-appropriate nurse and participants who viewed the image of an overweight nurse. Power calculation is provided for sample size.</p> <p>Participants may well have been from a socioeconomic group which was not recorded.</p>		<p>genuineness are more important in establishing patients' trust than is outward appearance</p>		
<p>(Dao Thi Minh et al., 2008) Vietnam</p>	<p>This QUANTITATIVE STUDY used a WHO adapted survey of 2151 health workers to investigate smoking patterns and compared knowledge beliefs and attitudes. Although this study included dentists and doctors its recommendations claimed that special attention should be given to the following slogan: "Health professionals should act as non-smoking role models for their patients and the public." It was argued that this message be incorporated into cigarette restriction regulations and policies at hospitals and recognised as one of the effective measures in cigarette</p>	8	Should be non-smokers	<p>Workplace support for healthy lifestyle -health providers smoking prevention programmes "Health professionals should act as nonsmoking role models for their patients and the public." This message to be incorporated into cigarette restriction regulations and policies at hospitals</p> <p>Belief that they can influence patients by being role models</p>	-

	control in the hospital context. Nurses were found to smoke less than doctors and dentists. Self reporting- social desirability bias. Cultural and gender diversity should be recognised when considering findings.				
(Brown and Thompson, 2007) UK	QUALITATIVE STUDY. (N=15). The aim of this study was to explore primary care nurses' attitudes, beliefs and perceptions of own body size in relation to giving advice about obesity. Findings suggested that a slim build nurse amplifies sensitivity surrounding obesity and can appear to lack empathy however those with large body size considered empathy their virtue but were concerned about being poor role models. Single method study- lacks triangulation	4	Caring-Empathy Self care by not smoking.	-	-
(Dobinson-Harrington and Cornforth, 2006) UK	This UNREFERENCED ARTICLE is presented as a debate between two nurses in a popular nursing journal entitled "Should nurses be healthy role models?" Unhealthy diets, smoking, and drinking alcohol are cited to be due to long hours, shift patterns, substandard hospital food and stress of working in a highly demanding environment	2	Caring- empathy Practise what they preach.	-	Nurses as leaders and champions in Public Health

(Cornforth, 2006)	This reference was for duplicate article above by both authors.	-	-	-	-
(Beletsioti-Stika and Scriven, 2006) UK	This QUANTITATIVE STUDY conducted in Greece used a cross sectional survey of qualified nurses (<i>n= 402</i>) to comparing smoking attitudes, influences on smoking behaviours and desire to quit with motivation to act as health promoters with patients and other health professionals who smoke. Over half were smokers. The main reasons given for continuing to smoke included using tobacco for enjoyment and as a coping mechanism for stress. Organisational problems were identified as the main source of stress. Finally, the majority of respondents considered the important part they can play as role models in promoting health behaviours in their patients. Validity: self-reporting respondent bias.	6	Self care	Address work place stress- needs of nurses need to be met in terms of reducing the factors that cause them to take up the smoking habit, particularly those linked to workplace stress.	-
(Slater et al., 2006) UK	This QUANTITATIVE STUDY explores the link between nurses' smoking behaviour. Knowledge of, and attitudes to smoking and willingness to play a health promotion role in facilitating cessation with patients. Although not identified in the aims and objectives three statements of	3	-	Workplace support for healthy lifestyle- Improvement of smokers' awareness of the benefits of cessation and appropriate support provided to smoking nurses.	-

	<p>the survey were aimed at measuring nurses' opinions of their function as a role model. Most felt that it was a personal matter whether they smoked or not; most felt that they should be an educator and to a lesser extent a role model. Most nurses who smoked wished to cease. The discussion made some observations about what is required to improve their status as a role model.</p> <p>Self reporting- social desirability bias.</p> <p>Low response rate 54%</p>				
(Yeh et al., 2005) Taiwan	<p>This MIXED METHODS PILOT STUDY evaluated the effects of a healthy lifestyle promoting program taught as part of undergraduate nursing curriculum. (<i>n=42</i>). The authors argued that including such programmes in curricula promotes the health of future nurses who will serve as positive role models to patients. The strength of this study was in the measurable impact of such a programme.</p>	3	-	<p>Understanding and application of health promotion in pre registered nurses-</p> <p>Educational provision of health promoting behaviours</p>	-
(Vieweg et al., 2005) USA	<p>QUANTITATIVE STUDY examined obesity of psychiatric staff. Findings suggest that black women working in the long term psychiatric institution</p>	5	-	-	-

	<p>were highly vulnerable to obesity and being overweight more so than the patients; impairing their capacity to educate and role model for their patients. Very limited study-one off measurement of staff with no consideration of variables. Used BMI only as measure of obesity and did not mention cultural expectations of weight.</p> <p>Did not identify whether direct staff are registered nurses or carers.</p>				
(Halcomb, 2005) USA	<p>This SCHOLARLY ARTICLE reviewed the diseases and illnesses related to smoking, considered economic impact of smoking and smoking cessation. It refers to the WHO 2004 code of conduct for health professional organisations to encourage and support members to be role models by not using tobacco and promoting a smoke free culture.</p>	4	<p>Self care by not using tobacco</p>	<p>Workplace support for healthy lifestyle - organisations 'will' assess and address tobacco consumption and tobacco control attitudes and implement appropriate policies.</p> <p>Occupational Health nurses must target registered nurses that smoke</p> <p>O H nurses can direct employers to choose health plans that reward non-smokers and provide reimbursement for smoking cessation, initiate on-site wellness programmes</p>	-

(Rush et al., 2005)	This SHORT ARTICLE was written as a response to Heims 2005 comment (below) regarding the authors study	7	Practise what they preach	-	Potential stress by the burden of expectation- The expectation creates problems for some nurses
(Heims, 2005)	This commentary OPINION PIECE was written in response to Rush (2005b) published study.	7	-	-	-
(Rush et al., 2005b) Canada	The aim of this QUALITATIVE EXPLORATORY STUDY was to discover how nurses described them selves as health promoting role models. 2 focus groups and 4 in-depth interviews ($n=15$) were conducted. Findings challenge views of the term role model. The concept of role modelling has both positive and negative meaning to the profession, and can make nurses feel threatened. For some the concept of being a role model creates a discomfort by the inconsistency between what they teach and what they do. Sampling does offer maximum variation across area of practice. Small sample size.	100+	Caring Inspiring and Motivating- being knowledgeable and empowering Trustworthy- gains trust is genuine Self aware- Engages with self reflection Non judgmental- Being on the same level and equal with patients not better or above them Outwardly observable healthy behaviours Accepting of self with imperfections	1. Attention should be given to who the nurse is not what she or he does. 2. Knowledge 3. A non-traditional approach to health promotion—one that counters the traditional, authoritative, prescriptive approach value self and values health “The role model for health promotion has been further defined in terms of empowerment and social-political activism” empowering. Social activism.	1. May result in aggressive condemning and arrogant attitudes 2. Nurses feeling threatened and uncomfortable by high and lofty expectations. 3. Creates a sense of separation and superiority. 4. Creates expectations that cannot be lived up to 5. Provides nurses with a non-threatening ideal for which to strive 6. Conveys a false reality

	This study does not identify barriers, facilitators or potential consequences which could add to understanding of interpretations. Although many attributes and antecedents are discussed many are relevant to the related case identified in this thesis		Lack of genuineness by playing a role and projecting a role, which denies the self and humanness. Being imperfect and sharing human struggles/ flaws can be used to motivate behaviour change		7. Creates a very real pressure on some nurses to meet the expectations of others 8. Violation of personal rights and freedom of nurses 9. A vision of the ideal role model and beliefs in the necessity of perfect lifestyle behaviors can be impediments to nurses' effectiveness in health promotion. Potential stress by the burden of expectation.
(Dunkley and Ward, 2005) UK	The two authors of this OPINION PIECE in a popular nursing journal debated whether nurses should be role models or not.	7	Caring –Empathy Non judgmental- Non-patronising approach Self care by not smoking	-	Validates and gives credibility of advice (patients more likely to heed advice)- Advice has credibility with the general public Conveys a positive health message
(Pollard, 2004) UK	This EDITORIAL of a peer reviewed nursing journal discussed whether nurses' should be expected to be role models in light of the CNO	3	-	Workplace support for healthy lifestyle- Help to be given to nurses who smoke to help them quit	Potential stress by the burden of expectation.

	announcement that nurses who smoke should be given help to quit so that they can the 'coincidentally become role models				Validates and gives credibility of advice (patients more likely to heed advice)
(Jaarsma et al., 2004) Netherlands	This QUANTITATIVE STUDY investigated the overall profile of cardiac risk factors of cardiac nurses to determine if they 'practised what they preach' using a self-reporting survey of (<i>n</i> =122) cardiac nurses from 19 countries. This study reconfirmed previous work that cardiac nurses heed their own advice and argues that they provide good role models for primary and secondary prevention initiatives. Sample from 19 European countries which increases generalisability of findings to Europe 47% response rate- those with higher CHD risk may not have volunteered.	2	Being an exemplar- Practice what they preach	-	Reduces Population Risk factors
(Baron-Epel et al., 2004) Israel	The aim of the QUANTITATIVE STUDY was to evaluate the prevalence of smoking among student nurses in Israel and to identify factors associated with students' attitude to their role in smoking prevention and to nurses as role models regarding smoking (<i>n</i> =782). Attitude to nurses	14	-	Workplace support for healthy lifestyle- effort to target smokers to quit and then to emphasise further the importance of being a role model.	-

	<p>as role models was the main variable explaining variance in attitudes to nurses' role in prevention. Smoking status and students' social environment exerted a marked influence on students' attitudes to smoking role modeling. A more holistic approach to student nurses' education about smoking prevention was called for by the authors.</p> <p>Sample from three academic schools</p> <p>Self reporting- social desirability bias.</p> <p>69% response rate. Many smokers may not have volunteered.</p> <p>Paper did not state which year of education students were engaged in and did not consider if this changed throughout education</p>				
(Denehy, 2003) USA	<p>EDITORIAL. The author discussed the health practices of school nurses and the obligation that they have to role model health practices to children and other staff</p>	5	<p>Self caring- Care for oneself so that one can care for others- managing stress, getting adequate sleep, good nutrition practices and involvement in a regular fitness programme.</p> <p>Being an exemplar- Living by example</p>	Obligation	-

(Chalmers et al., 2003) Canada	MIXED METHODS STUDY , which examined smoking habits of nursing students. Findings highlight some confusion about themselves as role models. Some claimed to feel hypocrites when they smoke. Students noted that in practice settings registered nurses offering smoking cessation smoked and were therefore not good role models to patients or students. (n=272.) Differences across the years of education were considered briefly (forth years more likely to consider smoking issues important) 62% response rate. Many smokers may not have volunteered Self reporting- social desirability bias.	4	Portray themselves in a healthy way.	-	-
(Sarna and Percival, 2002) UK	The two authors of this OPINION PIECE debated whether nurses should be role models. One argued that nurses are role models whether they want to be or not so therefore should consider their own health. The second argued that we should not ask it of nurses and that it is not a given status but a personal matter who an individual chooses to be their role model. "I would rather hear	14	Caring- Takes time to listen and explains challenges in a realistic and reassuring manner. Listens to peoples' problems, showing empathy and support.	Understanding and application of health promotion in pre registered nurses- Nurses entering the profession need to be equipped with knowledge, skills and support to make lifestyle changes during their training	-

	advice from a reformed sinner than a saint”				
(Fridlund, 2002)	This peer reviewed SCHOLARLY ARTICLE highlighted the role of the nurse in cardiac rehabilitation programmes. One reference was made to the fact that they should serve as good role models in the abstract but not within the paper itself.	1	-	-	-
(Shriver and Scott-Stiles, 2000)	This two year longitudinal MIXED METHODS STUDY explored whether exposure to nursing theory content and client interactions make any difference in the regular practice of positive health behaviors in nursing students when compared to non-nursing students ($n=154$). Nursing students were found to improve significantly in health habits compared to non-nursing students. Authors argued that the findings highlight the importance of emphasising self health care in nursing curricula to promote healthy lifestyle who can subsequently become role models. Triangulation is a strength of paper The qualitative stage only included 36 of the 71 so a low response rate which is not discussed in paper.	3	Self care	Understanding and application of health promotion in pre registered nurses- Learning the importance of being a good role model in nurse education	Behaviour change in others -Facilitates positive style changes in clients. Improves personal health Makes a difference to personal health habits

	Generalisability- a gender and age difference between nursing and non-nursing students produces confounding variable.				
(Hicks, 2000) UK	A diabetic nurse specialist who is also diabetic herself wrote this short OPINION PIECE in a popular nursing journal. She discussed how she does not use her condition to act as a role model for patients or colleagues because she is herself first and diabetic second.	2	-	-	-
(Laschinger and Tresolini, 1999) Canada	This QUANTITATIVE STUDY explores self-efficacy of (<i>n</i> =60) nursing and (<i>n</i> =41) medical students health promotion counseling. It refers to faculty role models only. One site study impacts on generalisability. The nursing sample was taken from a site which had improved new curricula health promotion input so may not reflect other schools.	6	-	-	-
(Huber, 1998)	This short LETTER TO THE EDITOR referred to Connolly's 1997 article about smoking and nurses.	1	-	-	-
(Connolly et al., 1997) USA	MIXED METHODS STUDY used health questionnaires and video recorded interviews to explore what critical care nurses are doing to keep healthy, whether they anticipate changing future lifestyle and whether they would recommend their own	6	1. Exemplars to patients Self care- Taking responsibility for own healthcare; watching weight, eating well, not smoking and	Understanding and application of health promotion in pre registered nurses- - Faculty members should do a better job of influencing students'	-

	<p>lifestyle to patients. 70% said that they would recommend their own lifestyle. A predominant theme in the results was that the majority of nurses had a positive attitude about their lifestyle and were optimistic about being role models to patients (<i>n</i>= 127)</p> <p>Self-reporting questionnaires offer response bias...it is noted that 43 nurse did not respond to a question asking if the currently smoked. Some triangulation.</p>		<p>exercising. Having work life balance</p> <p>Being an exemplar- Setting a good example and practicing what they preach</p>	health promoting behaviours	
(Ball, 1997) USA	<p>This EDITORIAL PIECE was prompted by a White House reception during National Nurse Week when President Clinton spoke of nurses as the leaders in promoting wellness and healthy lifestyles.</p>	3	<p>Be champions of health and wellness</p> <p>Truthfully recommend own lifestyle to patients</p>	-	<p>Validates and gives credibility of advice (patients more likely to heed advice)</p> <p>Validation of messages about healthy lifestyles</p>
(Padula, 1992)	<p>SCHOLARLY ARTICLE discussed the impact of smoking on practice nurses related to their ability to serves as health educators and role models and analysed smoking behaviour. Argued that nursing undisputedly has the greatest potential for impacting on the recipients of healthcare. The article refers to 1980 literature (Elkind</p>	7	-	-	-

	1980) which identified the lack of opportunity to fulfill the role of health role model as a contributing factor to high smoking rates among nurses due to stress and failure to teach health behaviours in the student nurse curricula. Smoking was discussed as a deterrent to successful modeling of the health exemplar.				
(Clarke, 1991)	SCHOLARLY ARTICLE focused on the role of the nurse as both a role model and as a health educator. It examined some key areas where tension between these two appears to exist. The author argued that nurses credibility does not necessarily emanate solely from their health related behaviours	23	Caring -being able to communicate with sincerity , warmth and empathy. Genuineness, warmth empathy and trust which makes intimacy possible Self aware - Personal effectiveness- confidence in self.	Value self - Education must include learning about 'self' . Nurses need to be helped to discover some positive aspect of their 'self' which can fit with role model theory and be helped to feel good about these discoveries.	-
(Kinney and Erickson, 1990)	SCHOLARLY ARTICLE discussed Modelling and Role Modelling theory (MRM) which is defined as when a nurse plans and implements interventions that are unique for the client and with respect of the nurses theoretical base. MRM was not well recognised as role modeling health promoting behaviour		Being non-judgemental and having unconditional acceptance Self awareness	-	-

(Soeken et al., 1989) USA	<p>QUANTITATIVE STUDY used a lifestyle questionnaire ($n=139$) to ascertain the extent to which senior level nursing students engaged in a wide range of preventive behaviours and compared these preventive behaviour levels to a random sample of the United States population involving the same general age range and sex. A second purpose was to identify determinants of healthy behaviours among these students in order to provide the basis for changing those behaviours deemed dangerous to their future health and nursing role. The authors claimed that because the practice of these behaviours may affect one's effectiveness as a role model, it is important to determine whether nurses lead a so-called preventive lifestyle and to identify what factors are predictive of compliance. Nursing students found to be significantly less compliant to 12 of 19 preventative behaviours than a national female sample. Unvalidated questionnaire however was tested and re- tested on 20 students. 100% response rate. One site study</p> <p>Self reporting questionnaires offers</p>	4	-	<p>Understanding and application of health promotion in pre registered nurses</p> <p>- Before nurses can be role models they must incorporate the following into their own personal lifestyle; smoking cessation, adequate exercise, balanced nutrition intake, monthly breast examination and control of stress</p>	-
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	response bias				
(DeMello et al., 1989)	This QUANTITATIVE STUDY used The Nurses' Anonymous Questionnaire on Smoking to gather information on smoking prevalence in various areas of practice and attitudes toward the educator and exemplar role (<i>n=120</i>). 93% felt they should set a good example by not smoking. 43.9 % were former or current smokers. 27.2 % were current smokers. Reliability and Validity of measurement tool- Validated questionnaire was used.	3	Being an exemplar- Exemplar role for the public to follow	Workplace support for healthy lifestyle- Clinical specialist should provide support for nursing personnel including smoking cessation programmes and a smoke free worksite	-
(Glugover, 1987) USA	This UNREFERENCED ARTICLE discussed how community nurses responded to new demands in healthcare and be advocates for change for others	3	Caring- intuitive and sensitive. Giving hope Trustworthy- consistent Advocates for change. Being assertive Influencing Works in a way that promotes learning and	-	-
(Curtin, 1986) UK	This EDITORIAL is an amusing 'tongue in cheek' piece entitled the case of the reluctant role model: from heresy to health. It claimed that the nursing profession is full of health zealots and argues that it should stop before there are no	2	Non judgmental- Not being too obvious or arrogant or self righteous	-	-

	honest nurses left. Although not scholarly this piece is referenced in several other articles.				
(Aucoin, 1986) USA	This SCHOLARLY ARTICLE discussed smoking behaviour and efficacy of nurses as role models. It argued that more effective educational programmes are necessary for all nurses and student nurses regarding the health hazards of smoking. The article mostly focused on historical and political points surrounding smoking in the USA.	3	-	Understanding and application of health promotion in pre registered nurses- Effective educational programmes concerning health hazards of smoking for all student nurses and nurses Understanding of health promotion in registered nurses -Programmes and clinics that emphasise to nurses that important knowledge is imparted to their patients by attitude as well as through instruction.	Reduces Population Risk factors- Elimination or greatly reducing of health risk
(Dalton and Swenson, 1986) USA	The purpose of this QUANTITATIVE STUDY was to explore role modeling beliefs and behaviours of smoking and non-smoking nurse in relation to patients (<i>n= 601</i>). Higher proportion of non-smokers felt that they should practice good health behaviours to be good role model.	25	Exemplars for clients, Individuals from whom performance can be observed and learned Inspiring and motivating- Responsible for motivation and production of goal	Positive image of nursing- Accepted as knowledgeable Workplace support for healthy lifestyle- Smoking cessation programmes for nurses	Behaviour change in others.- Contributes to change in smoking behaviours that are socially learned, purposive and functional Positive influence on the health of the public

	Twice as many non-smokers than smokers said they counsel patients on smoking. Recommendations were made for nurses to demonstrate good behaviour in private and professional life and Smoking Cessation support for nurses recommended in order for them to become role models. Unvalidated tool was reviewed for face validity by 50 nurses Response 46% Sample was 5% of all nurses in state		directed behaviour or apathy (negative) Providers of good care		
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BNI

“ Role model* “AND nurs* AND health* in abstract

1983-2015

73 HITS

Excluded tributes and obituaries

Excluded those not relevant to role modelling health-promoting behaviour.

Total **9** retrieved after removal of duplicates

Citation	Summary	Instances	Defining Attributes	Antecedents	Consequences
(Young et al., 2013) AUS	This SHORT REFERENCED ARTICLE discussed a Safe Infant Sleeping eLearning program and nurses role in role modeling clinical practice	2	-	-	-
(Connolly et al., 2013)	QUANTITATIVE STUDY. Survey to examine beliefs of mental health nurses about smoking by nurses,	5	Self care	Workplace support for healthy lifestyle- Support should be provided to	

	clients and visitors. Findings show that half of the respondents considered smoking was important to creating a therapeutic relationship with the patient. The authors reflected on how the findings suggest the effect of positive role modeling if nurses continue to smoke with patients. (<i>n=104</i>) Response rate low 17% suggesting that data may not be representative of population			nurses with nicotine dependency to become smoke-free	
(Eggertson, 2013) Canada	UNREFERENCED ARTICLE considered the nature of the work of nurses and the culture of the workplace from a perspective of “is it fair for the public expectation for nurses to be role models?” It included in it’s discussion findings of Kathy Rush (2005b) and the concept of imperfect role models	4	Self care Healthy living	<p>Address work place stress- Bullying, violence in the workplace, lack of respect and addressing the challenges of shift work in a 24/7 business are essential</p> <p>Workplace support for healthy lifestyle- Workplace health and safety- safe staffing levels, shift work accommodations (e.g allowing short naps and healthier food available)</p> <p>Support from people in their social network.</p>	Behaviour change in others- Helps patients make changes in their lifestyle .

(Trossman, 2013) USA	SHORT ARTICLE reflected on the Healthy Nurses Program and focused on nurses attaining healthier lifestyles and workplace practices to be strong role models for patients	2	-	<p>Clear policies and procedures that reduce stress and hazards in the environment, such as having safe patient handling and anti-bullying programs.</p> <p>Workplace support for healthy lifestyle Employers offering health and wellness programs such as nutritional counseling, fitness programs and healthy food choices in the canteen. Employers rethinking practices e.g allowing staff to engage in meditative rest during breaks</p> <p>Address work place stress</p>	-
(Hagglund, 2009)	This CASE STUDY focused on applying a modeling and role modeling approach (MRM) with a patient suffering with a fictitious condition. The use of the term role modeling in this instance does not refer to promoting healthy behaviours	4	Non-judgemental and having unconditional acceptance	-	-

(Holt, 2008) UK	This SCHOLARLY ARTICLE discussed Manchester University's considerations of how to improve the BSc Nursing programme to prepare undergraduate nurses as future promoters of health and well being. The author stated that it is accepted within the profession that nurses act as role models to patients and communities.	4	Internalising the meaning of good health	Understanding and application of health promotion in pre registered nurses	Validates and gives credibility of advice (patients more likely to heed advice) Projecting of positive health messages.
(Holt and Warne, 2007) UK	QUALITATIVE STUDY (<i>n</i> = 100) explored how placing a greater emphasis on the role of the nurse in health promotion in the curriculum impacted on their preparation for practice. The findings suggested a dichotomy between what is espoused in the underpinning theory of the curriculum and what the student nurses actually experience in practice. Focus group themes were tested with themes arising from student evaluations, which offered some triangulation.	4	Exemplar- Setting an example to patients and communities	Understanding and application of health promotion in pre registered nurses Curriculum needs to prepare with knowledge about a wide variety of health promotion topic to develop confidence and skills to apply them in practice	Considers cognitive Dissonance with some student nurses in discussion
(Narayanasa my and Narayanasa my, 2006) UK	REFERENCED OPINION PIECE reflected on whether nurses are credible health promoters	1	-	-	-
(Borchardt, 2000)	REFERENCED ARTICLE discussed the challenge for nurses as role models	15	Self Aware- of one's own self care patterns	Caring - Emphasis on the importance of the	-

	for health promotion. The author provided practical tips for nurses to take their own advice from the information and teaching that they might provide to a patient		Self caring- Be capable of caring for both themselves and others Exemplar- Promote healthy living by example	communicators personal characteristics in promoting behaviour change Positive image of nursing- Respect for the model and a perception that the model is competent, powerful and attractive	
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CINAHL

“ Role model* “AND nurs* AND health* in abstract

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Citation	Summary	Instances	Defining Attributes	Antecedents	Consequences
(Chan, 2014) China	CROSS-SECTIONAL QUANTITATIVE STUDY explored the psychological factors associated with the exercise behavior of nursing students. (<i>n=195</i>). Fatigue brought on by exercising was the greatest perceived barrier to exercise, whereas increasing physical fitness and mental health were the greatest perceived benefits of exercise. Male	5	-	Understanding and application of health promotion in pre registered nurses- Nurse educators to develop strategies to enhance nursing students' exercise behavior e.g using pedometers, encouraging outdoor	-

	<p>students were found to be within optimum exercise activity whereas female were below. The authors stated that nurses are expected to be role models in health promotion and argued that nurse educators can endeavor to promote exercise behavior among nursing students by highlighting the specific benefits of exercise, empowering students to overcome their perceived barriers to exercise, and enhancing students' exercise self-efficacy. Generalisability may be limited due to participants from one year in one university. Exercise was measured by duration and did not include duration.</p>			activity particularly for female students	
(Clark et al., 2007)	<p>Three authors individually reflected on whether nurses have a responsibility to be role models in this OPINION PIECE. All three argued against nurses being healthy role models stating that having the same problems as patients provides a connection with them, that the nurse population should reflect the general population and that nurses are not servants of the state in this or on any other matter.</p>	1	-	Nurse leaders as healthy role models	-
(Houghton et al., 2005)	<p>This readers panel SHORT ARTICLE captured four nurses brief response</p>	3	-	-	-

	to whether nurses should be good role models for a healthy lifestyle? One individual is in favour although the other three suggest that it is not realistic				
(O'Connor, 2002) USA	SCHOLARLY ARTICLE discussed how nurse leaders need to 'prioritise self' while creating a healthy lifestyle acting as role models to the workforce. The author argued that a self-care regime for nurses can have and impact on patients because they truly experience what they ask their patients to do. This article focuses on a holistic approach to self-care.	3	-	Nurse leaders as healthy role models	-
(Kamwendo et al., 2000) Sweden	This QUANTITATIVE STUDY ($n=204$) compared nursing and physiotherapy students on a number of lifestyle and health indicators. Results: physiotherapy students were more physically active, smoke less, eat fewer sweets and unhealthy snacks compared to nursing students. The authors claimed the findings question the credibility of student nurses as role models. Questionnaire piloted and reliability and validity is explained well. Data collected from 3 universities. Very high response rate 98.5%	6	Has shared the patients problem rather than 'next to perfect'	Understanding and application of health promotion in pre registered nurses- Curriculu must not only comply with medical knowledge but take into consideration the student' own health attitudes and behaviour.	-

PubMed

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Snowballing and Provided by Expert

Citation	Summary	Instances	Defining Attributes	Antecedents	Consequences
(Malik et al., 2011)	QUANTITATIVE STUDY expanded on the Blake (2011) study by comparing the self reported health and lifestyle behaviour of pre- reg and RNs in a UK hospital (<i>n</i> =876). Findings: with the exception of smoking registered nurses generally had a healthier lifestyle than student nurses but overall 50% failed to meet physical activity recommendations, two thirds did not consume 5 fruit or veg a day and almost half ate foods high in fat and sugar on a daily basis. Much of the discussion focused on barriers to healthy behaviour	5	Championing health and wellness- Serve as a point of reference for positive health habits which may be imitated by patients	Supportive practical workplace initiatives- Tailored healthy lifestyle programmes to eliminate barriers Understanding and application of health promotion in pre registered nurses- Educating pr-reg nurses about the importance of transferring their knowledge to their own behaviour Understanding of health promotion in registered nurses- Targeting of education and services to	Delivery of government policy (UK and International) Promotion of government messages concerning healthy lifestyle choices May help nurses cope with stress of profession

				improve diet and exercise habits of nursing professionals	
(Valentine and Hadeka, 1986) Canada	<p>Entitled Do Nurses Practise What They Preach? a QUANTITATIVE STUDY conducted to question the impact on promoting health behaviours if nurses do not practice good health themselves. The results are reported in very limited fashion. (<i>n=608</i>) questionnaires identified that only one half of the participants conduct Breast Self Examination, 51% never or occasionally wore a seat belt, smoking rates were lower than general population (although the authors suggest that many smokers did not volunteer). 36.7% exercised very seldom. Daily alcohol consumption was 4.1 %.</p> <p>Overall the authors suggested the study shows the need for nurses to place greater emphasis on their own health behaviours. The term exemplar role is used identifying that this role falls short if behaviours betray what is taught.</p>	0	-	-	-

(Blake and Patterson, 2015) U.K.	<p>QUALITATIVE STUDY used a self-reporting questionnaire on weight, diet, physical activity and attitudes towards nurses as role models for health. (<i>n</i>=67) of registered paediatric nurses from 14 wards. Participants completed 11 items on the questionnaire surrounding their attitude towards being role models for health. 84% believed they should present themselves as role models for health, 48% reported difficulty with promoting behaviours they did not adhere to themselves. 77% considered patients and families would heed advice better from those who appeared to follow it themselves. Views were inconsistent with their own lifestyle choices, which demonstrated that almost half were unhealthy weight, the majority did not eat 5 fruit or vegetables a day and one third did not meet physical activity recommendations. The authors briefly discussed possible cognitive dissonance between behaviour, health status and beliefs. Refers to connecting with patients by being a 'real person' rather than an ideal 'perfect role model' (related case)</p>	21	<p>Self care- Engage in healthy lifestyles 3. Physical appearance and weight status influencing how they are perceived.</p> <p>Exemplars for health behaviours- Practicing what you preach</p> <p>Championing health and wellness Facilitator for promotion of healthy eating</p>	-	<p>Validates and gives credibility of advice (patients more likely to heed advice) -children and families more likely to follow advice of a healthy role model</p> <p>Potential stress by the burden of expectation. Adds pressure to what is already regarded as a stressful profession</p>
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